

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Horace Calvin						ADAMS	Month	Day	Year	11:50 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male		White		Sept. 18, 1891			76		MONTHS		DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Md.		U. S. A.					Wicomico Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Retired Farmer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Delaware			Sussex		Federalburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R. F. D.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last Roger E. Adams			First Middle Last Virginia Morris Adams								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
no			220-34-9493		Mrs. Myrtle Adams, Hickman			Federalburg R.F.D.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lungs; post-</u>										not	
1621 DUE TO, OR AS A CONSEQUENCE OF										14 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>bronchoscopy bleeding</u>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
163x											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from April 2, 1968, to April 8, 1968, that (I) (we) last saw the deceased alive on April 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 11:50 P. M.											
22b. SIGNATURE								22c. DATE SIGNED			
William P. Sadler											
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS			
William P. Sadler								Medical Center - Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		April 12,		Bloomery		Federalburg, Md.		R.D.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
X. Harvey Williamson				Federalburg,				DATE APR 17 1968		Charles Judge	

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]*

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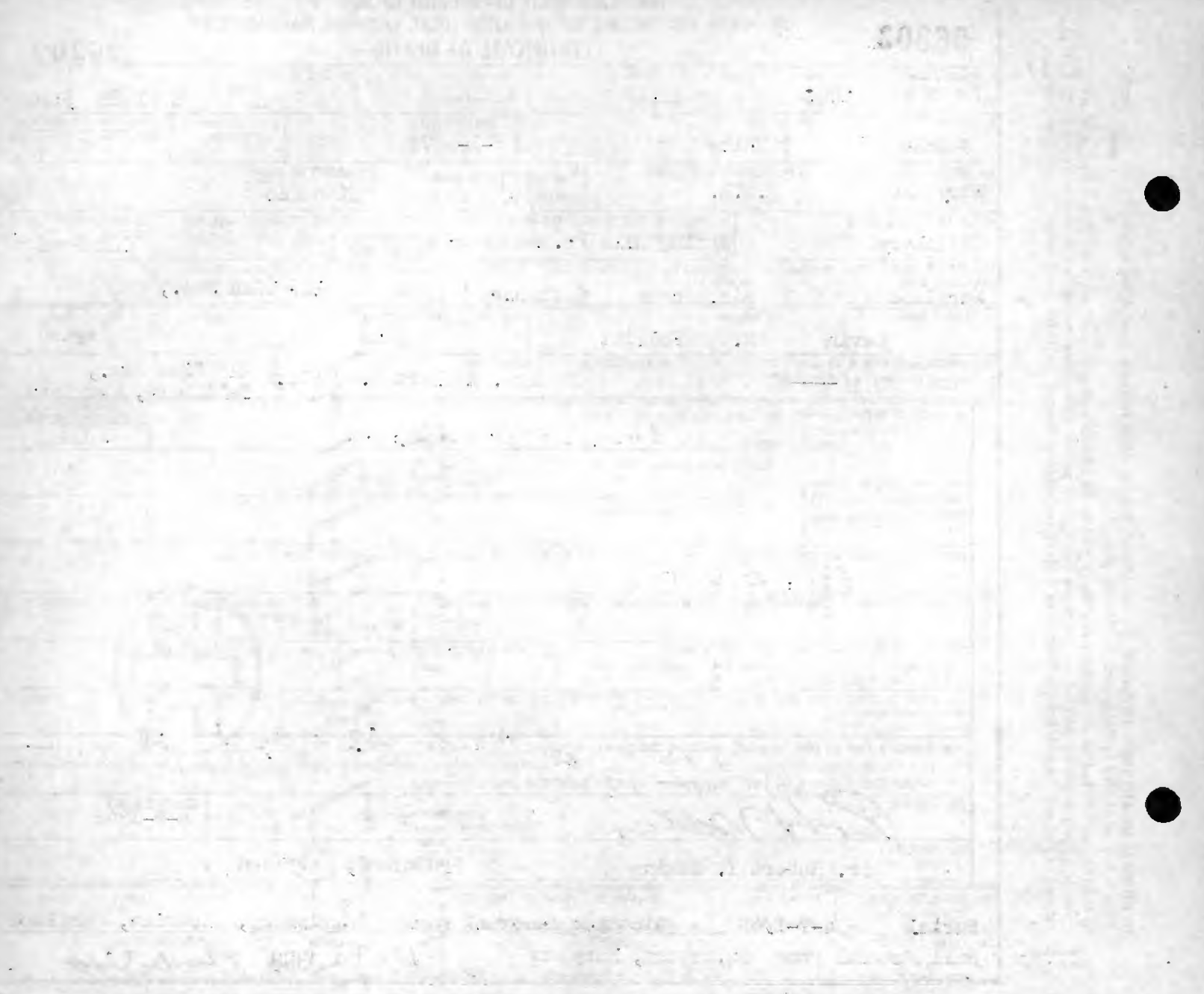
VR A15 (4)  
30A REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last LUCY ELLEN ADKINS			2a. DATE OF DEATH Month Day Year 4 8 1968			2b. HOUR 5:40 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 8-1-1879		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.				
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Spring Hill Pr. Sanitarium			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House Wife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 215 Glen Ave.,	
14. FATHER'S NAME First Middle Last Levin R. Pollitt				15. MOTHER'S MAIDEN NAME First Middle Last Emma Peyton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Herbert G. Wallace 215 Glen Ave., Salisbury, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>485 X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>493 X A.S.C.V.D.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>68</u> , to <u>April</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Robert T. Adkins</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 4-8-1968		
22d. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins					22e. ADDRESS Fruitland, Maryland					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-9-1968		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland				
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland <u>Norman T. Baker</u>					25a. REC'D BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>06304</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>06310</div>										
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR	
Calvin James Anderson						Month Day Year			7:35 M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR	
M	C	3-75-30	38 YRS.			Month Day Year			7:35 A.M.	
7a. BIRTHPLACE (State, or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Wicomico		SA				Wicomico Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md.			Wicomico			Salisbury			756 East Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MARRIED NAME First Middle Last							
Edward Anderson			Sally J. Zook							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
No						Ed. Anderson				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Generalized peritonitis										hours
533.3 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Incarcerated diaphragmatic hernia-left										days
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
5614										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
4-3-68			Incarcerated diaphragmatic hernia							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			M.D.			22b. DATE SIGNED				
Earl L. Royer, M.D.						4-10-68				
EXAMINER'S NAME (Type)			ADDRESS (Street, city, town, or county)							
409 Camden Ave. Salisbury, Md.										
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			4-13-68			Green Acres Cem			Salisbury Wicomico Md	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
West Funeral Home			Salisbury, Md.			DATE 4-15-68			[Signature]	

20332

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11. *Chrysomelidae* (100%)

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26



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Item 6 Film G398 1/15/68  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Homer BROWN Bailey			2a. DATE OF DEATH Month Day Year April 2 68			2b. HOUR- 4:42 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 10, 1893		6. AGE (In years last birthday) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Wicomico		13c. CITY OR TOWN Delmar		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D. I	
14. FATHER'S NAME First Middle Last Robert Bailey			15. MOTHER'S MAIDEN NAME First Middle Last Nora Halton						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 219-03-2191		17. INFORMANT William M. Bailey		Address R21 Delmar, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thromboses 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 da.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(c) 332x									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 3-29, 1968, to 4-1, 1968, that (I) (we) lost saw the deceased alive on 4-1-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William B. Colby				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 4-1-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4/4/68		23c. NAME OF CEMETERY OR CREMATORY Melson Cem.		23d. LOCATION (City or Town) (County) (State) Delmar Wicomico Md			
24. FUNERAL DIRECTOR William M. Morrel				ADDRESS Delmar, Del.		25a. REC'D BY REGISTRAR DATE APR 11 1968		25b. REGISTRAR'S SIGNATURE James J. Jones	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <u>JOHN</u> First <u>RAYMOND</u> Middle <u>BAKER</u> Last						2a. DATE OF DEATH Month <u>APRIL</u> Day <u>23</u> Year <u>1968</u>		2b. HOUR <u>9</u> M <u>PM</u>	
3. SEX <u>White</u> - <u>MALE</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>JULY 23, 1898</u>		6. AGE (In years last birthday) <u>69</u> YRS.		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> IF UNDER 24 HRS. HOURS <u>0</u> MIN <u>0</u>	
7a. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Wicomico</u> Md.			
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Peninsula General Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>RETIRED</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>DELAWARE</u> COUNTY <u>SUSSEX</u>		13c. CITY OR TOWN <u>DAGSBORO</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>—</u>			
14. FATHER'S NAME First <u>JOHN</u> Middle <u>H.</u> Last <u>BAKER</u>				15. MOTHER'S MAIDEN NAME First <u>LAVINIA</u> Middle <u>W.</u> Last <u>BAKER</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name (unknown) <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>221-12-4390</u>		17. INFORMANT Address <u>HILDA S. BAKER, DAGSBORO</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURED ABDOMINAL ANEURYSM</u> <u>441.2</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>451X</u>									
19a. DATE OF OPERATION <u>4/22/68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ABOVE</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>—</u> Month <u>—</u> Day <u>—</u> Year <u>19</u> P.M. <u>—</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <u>—</u> City or Town <u>—</u> County <u>—</u> State <u>—</u>					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>68</u> , to <u>4/22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/22</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John M. Bloxom III</u> M.D. DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>4/24/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM III</u>				22e. ADDRESS <u>SALISBURY, MARYLAND 21801</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>APRIL 25, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MILLSBORO Cem. Inc.</u>		23d. LOCATION (City or Town) <u>MILLSBORO</u> (County) <u>SUSSEX</u> (State) <u>DE.</u>			
24. FUNERAL DIRECTOR <u>J. Douglas Nelson, Tronolite, Del.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 7 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV 1-58

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>First</b> <i>Eva</i> <b>Middle</b> <i>BEAUCHAMP</i> <b>Last</b>						2a. DATE OF DEATH Month <i>APRIL</i> Day <i>26</i> Year <i>1968</i>			2b. HOUR <i>12:30</i> M			
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>MAY 5 - 1894</i>			6. AGE (in years lost birthday) <i>73</i> YRS.		7. UNDER 1 YEAR MONTHS <i>—</i> DAYS <i>—</i>		8. UNDER 24 HRS HOURS <i>—</i> MIN. <i>—</i>	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.						
10. CITY OR TOWN OF DEATH <i>Salisbury</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY <i>RETIRED</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>MARYLAND</i>				13b. COUNTY <i>Somerset</i>		13c. CITY OR TOWN <i>CHANCE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>MAIN ROAD</i>		
14. FATHER'S NAME <b>First</b> <i>JOHN</i> <b>Middle</b> <i>PARKS</i> <b>Last</b>				15. MOTHER'S MAIDEN NAME <b>First</b> <i>NETTIE</i> <b>Middle</b> <i>JONES</i> <b>Last</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>NO</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <i>UNKNOWN</i>		17. INFORMANT <i>Eva B. ANDERSON - DEAL ISLAND MD 21021</i> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMATOSES</i> <i>1530</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ADENOCARCINOMA BT COLON</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>3 YRS</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>9 MOS</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>1530</i>												
19a. DATE OF OPERATION <i>9/10/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>INT. OBSTRUCTION</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>9/10</i> , 1967, to <i>4/26</i> , 1968, that (I) (we) last saw the deceased alive on <i>4/26</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John M. Bloxom II</i> M.D. DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE, SIGNED <i>4/28/1968</i>						
22d. PHYSICIAN'S NAME (Type) <i>JOHN M. BLOXOM II</i>						22e. ADDRESS <i>SALISBURY, MARYLAND</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>4-28-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>ROCK CREEK CEMETERY</i>			23d. LOCATION (City or Town) (County) (State) <i>CHANCE Som. MD</i>					
24. FUNERAL DIRECTOR <i>Leroy Webster Princess Anne Md</i>						25a. REC'D BY REGISTRAR <i>11/11/68</i> DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>LAURA -- BENNETT</b>						2a. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>68</b>			2b. HOUR <b>11:20</b> AM		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>October 15, 1889</b>			6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <b>Peninsula General Hospital</b>			12a. USUAL OCCUPATION (Kind of work done last birthday, if retired) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Route #1, St. Luke Road</b>		
14. FATHER'S NAME First <b>George</b> Middle <b>Denson</b> Last <b>Denson</b>				15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Butler</b> Last <b>Butler</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO		17. INFORMANT (daughter) <b>Miss Helen Webb, Baltimore, Maryland</b>			Address <b>816 Park Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Streptococcal infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>gastro</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> to <b>April 1968</b> , that (I) (we) last saw the deceased alive on <b>April 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Robert T. Adkins</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>15 April 68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Dr. Robert T. Adkins</b>						22e. ADDRESS <b>Fruitland, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 18, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Worcester Co., Md.</b>					
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b> ADDRESS				25a. REC'D BY REGISTRAR <b>DATE APR 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					





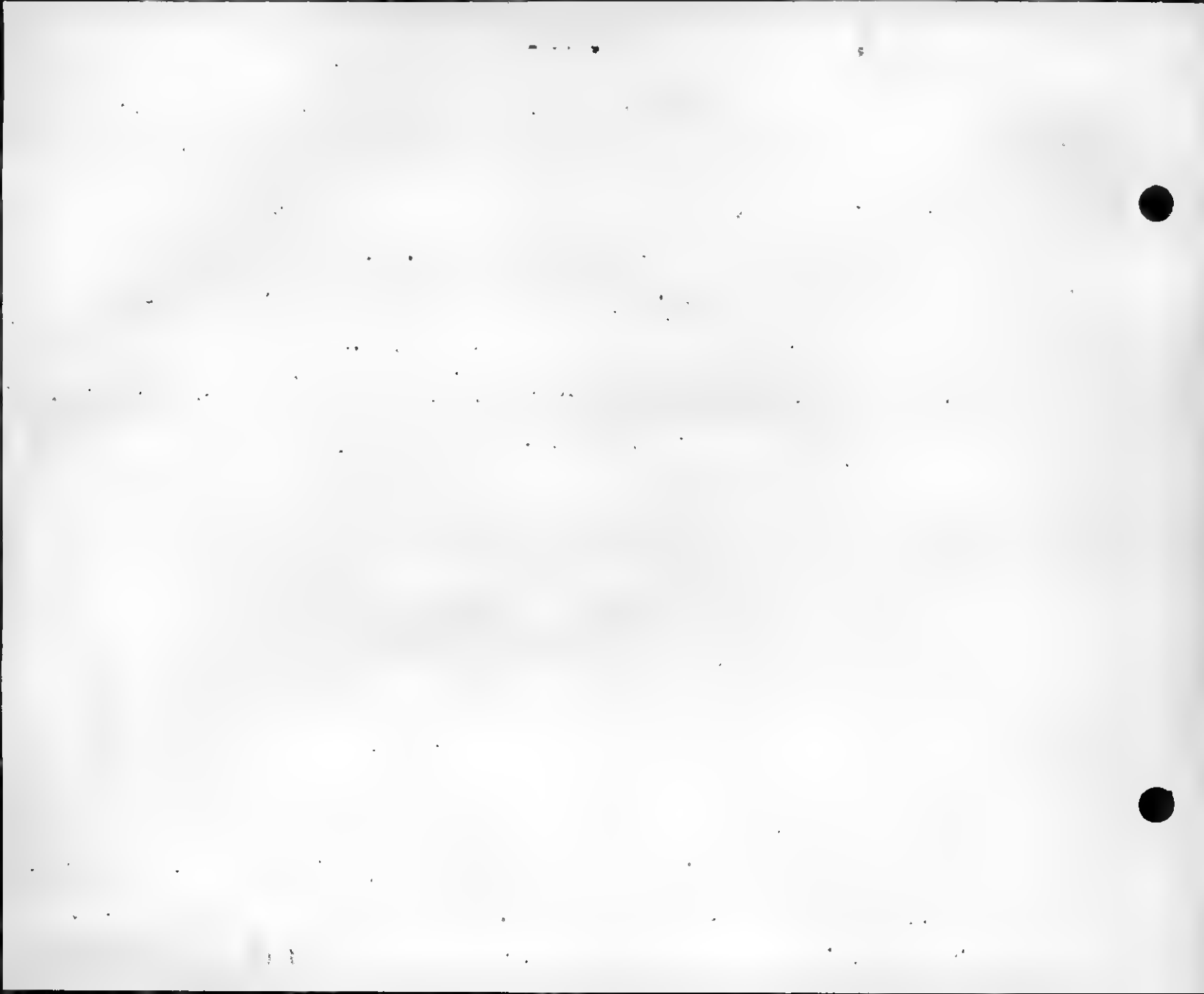
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last <b>WILLIAM HENRY BENNETT</b>			2a. DATE OF DEATH Month Day Year <b>April 18 1968</b>		2b. HOUR M <b></b>
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 4, 1877</b>	
6. AGE (In years lost birthday) <b>90</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>WICOMICO</b>		Md			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springhill Sanitarium</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Engineer &amp; Boiler Maker Railroad</b>	
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>#99 Sylvia Street</b>			
14. FATHER'S NAME First Middle Last <b>Franklin Pierce Bennett</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Josephine Lopes</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>Spanish American 215-14-3303</b>		17. INFORMANT (Daughter) Address <b>R.D.#6, Calhoun Ave.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
4-2-68					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3-2-1962</u> , to <u>4-18-1968</u> , that (I) (we) last saw the deceased alive on <u>4-12-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Philip A. Insley</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>April 19 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b>		22e. ADDRESS <b>116 E. Main Street, Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 20, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Wicomico, Maryland</b>					
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		ADDRESS		25a. RECEIVED BY <b>APR 23 1968</b>	
				REGISTERED SIGNATURE <u>Charles Judge</u>	



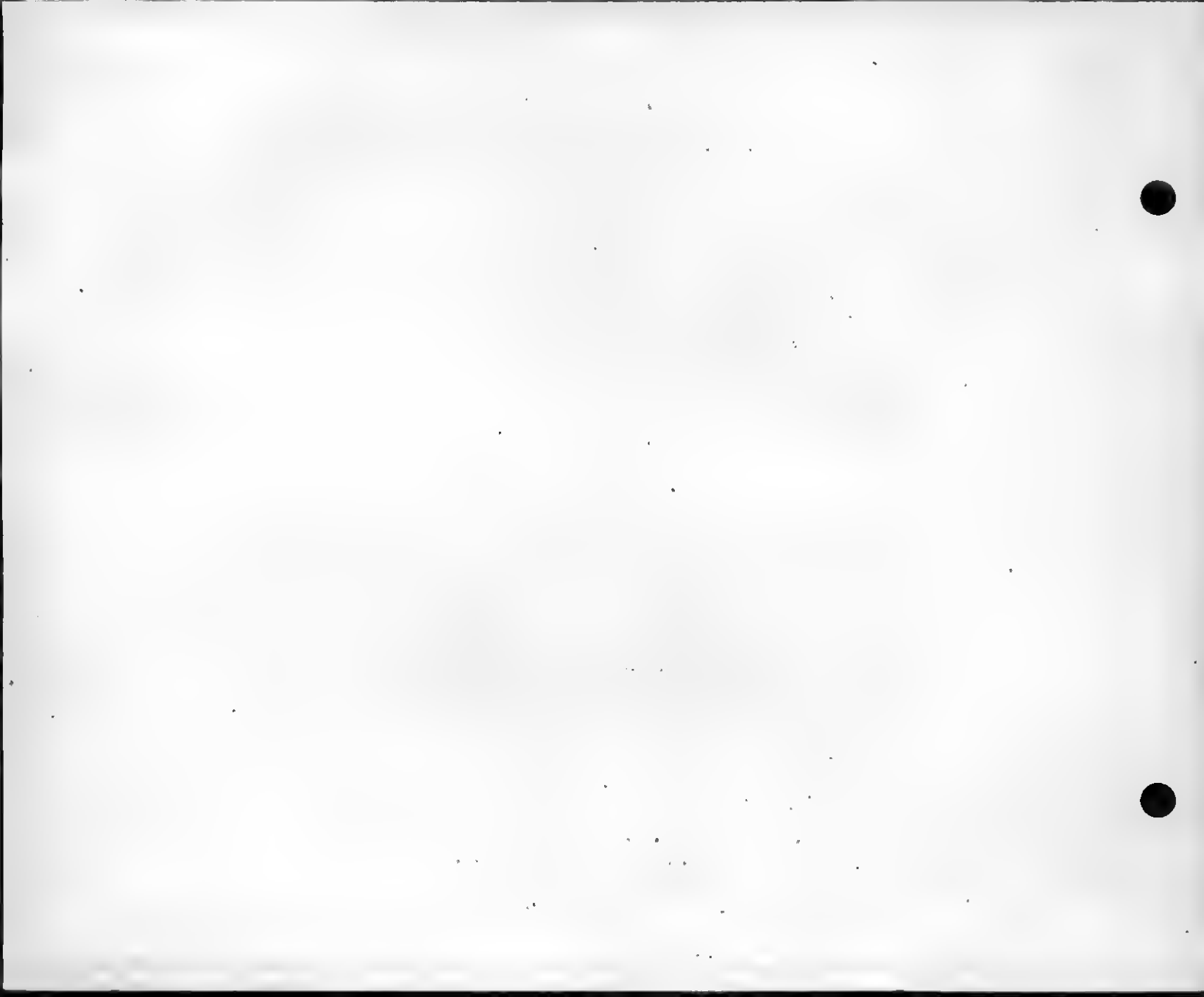
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) First Middle Last <b>FRED E. BETHARDS</b>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>4-20-68 19</b>			2b HOUR <b>4:45 P M</b>			
3. SEX <b>M</b>	4 RACE <b>W</b>	5 DATE OF BIRTH <b>3-16-94</b>	6 AGE (In years last birthday) <b>74 YRS</b>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year <b>4 20 1968</b>			2d HOUR <b>4:45 P M</b>
7a BIRTHPLACE (State or foreign country) <b>BERLIN MD</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Wicomico</b>			
10 CITY OR TOWN OF DEATH <b>Salisbury</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>NEWSPAPER</b>			12b. KIND OF BUSINESS OR INDUSTRY
13a USUAL RES DENCE (Where deceased lived, if institution admission) STATE <b>Md.</b>			13b. COUNTY <b>Wicomico</b>		13c CITY OR TOWN <b>Salisbury</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>526H Alabama Ave.</b>		
14. FATHER'S NAME First Middle Last <b>JOSIAH BETHARDS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>SARAH ENNIS</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>MOULD W. 136-05-0978</b>			17 INFORMANT <b>MRS. F. H. BETHARDS</b>			ADDRESS <b>526 ALA. AVE. SALISBURY MD</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Crushed chest</b> DUE TO, OR AS A CONSEQUENCE OF (c) And those, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>1120</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>8164</b>									
19a. DATE OF OPERATION <b>4-10-68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Tracheotomy</b>				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year <b>1:45 PM 4-9-68</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Driver of auto colliding with another vehicle.</b>				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>road</b>		21f LOCATION Street or RFD No City or Town County State <b>Quantico Road, Salisbury, Wicomico, Md</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>April 22, 1968</b>			
EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b DATE <b>4/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS CHURCH ARL</b>		23d LOCATION (City or Town) (County) (State) <b>BERLIN WIC. MD</b>			
24. FUNERAL DIRECTOR <b>Burbage Funeral Home, Berlin, Md.</b>				ADDRESS		25a REC'D BY REGISTRAR <b>APR 25 1968</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



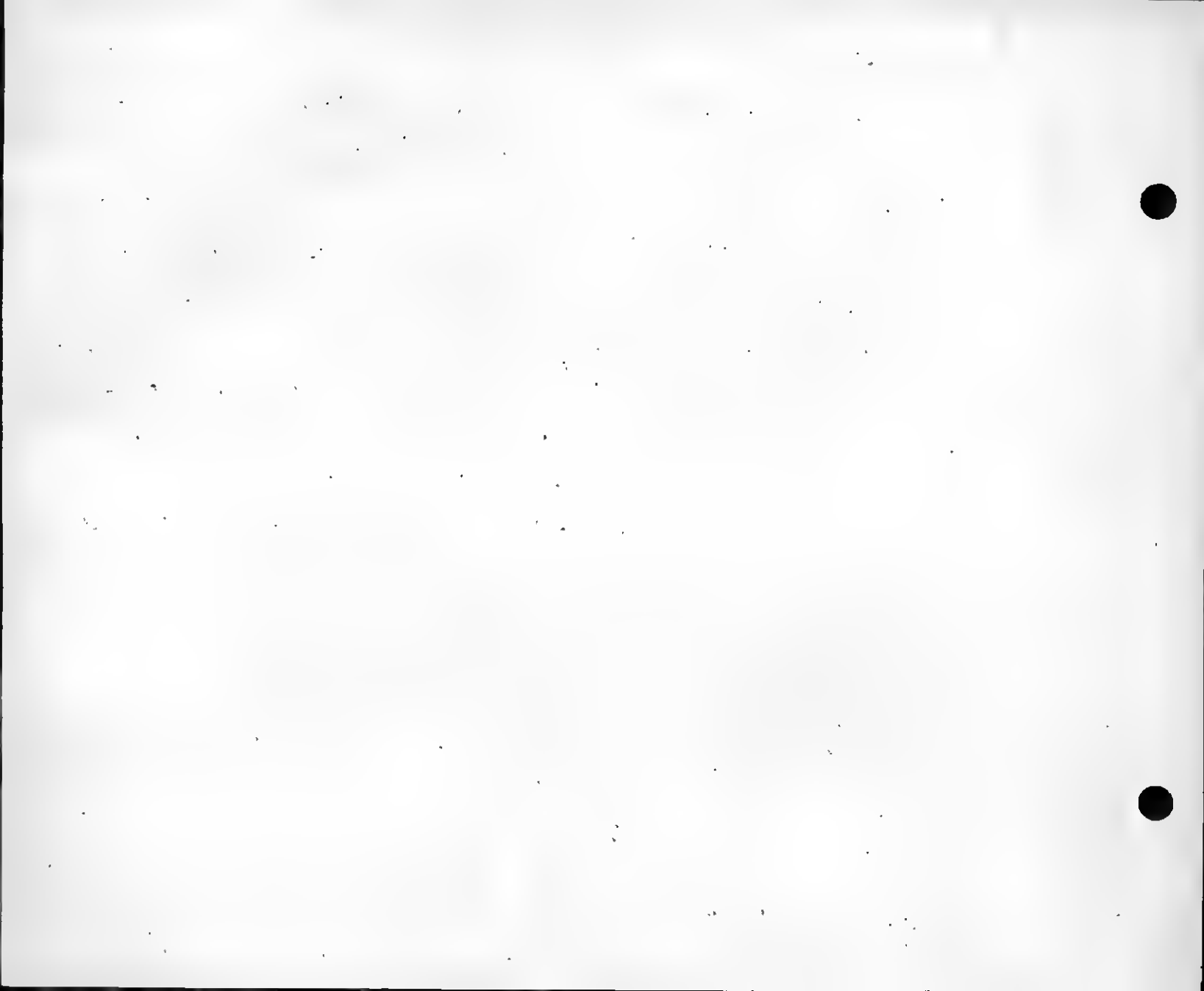
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VR 1114  
304 REV 1/68

MD 211  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last NAN Elizabeth BRADLEY			2a. DATE OF DEATH Month Day Year APRIL 27 1968			2b. HOUR 4:30 PM	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH 4-23-1892		6. AGE (In years last birthday) 76 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nurse	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE MARYLAND		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 615 Smith ST.		14. FATHER'S NAME First Middle Last Thomas J. BRADLEY		15. MOTHER'S MAIDEN NAME First Middle Last Eda WoolLEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO 320-34-9590		17. INFORMANT Mrs. Joseph Shorley Rt. 1 Marlboro, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4107 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute congestive failure hrs DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease yrs							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 4-26, 1968, to 4-27, 1968, that (I) (we) last saw the deceased alive on 4-27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John Bulkeley, M.D.				DEGREE M.D.		22c. DATE SIGNED 4/27/68	
22d. PHYSICIAN'S NAME (Type) John Bulkeley				22e. ADDRESS Five Bluff Road, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-29-1968		23c. NAME OF CEMETERY OR CREMATORY EAST NEW MARKET Cem.		23d. LOCATION (City or Town) (County) (State) E. NEW MARKET, Dor. Md.	
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Md.				25a. REC'D BY REGISTRAR DATE MAY 01 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	





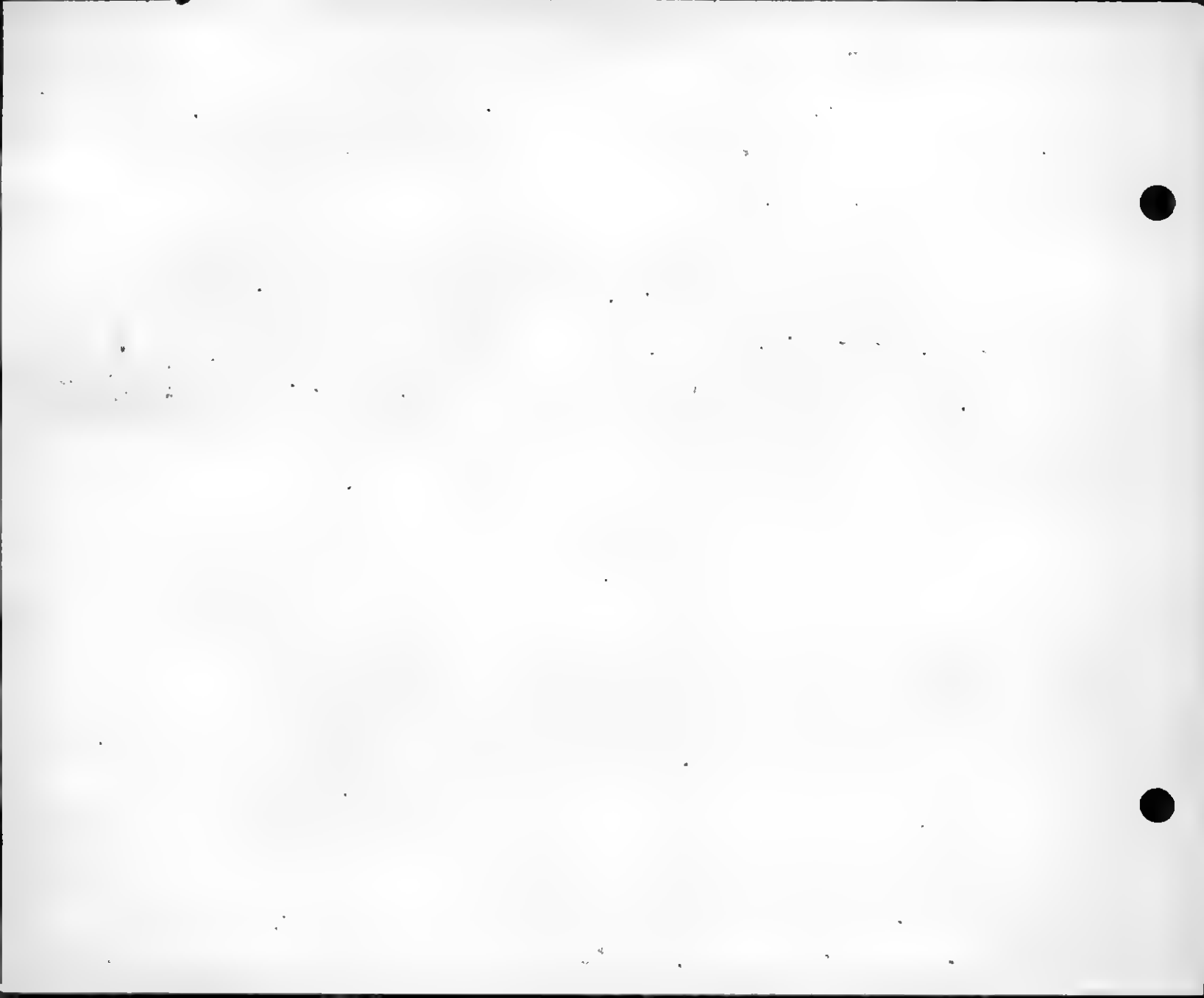
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VR A 101  
30M REV 10-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Lillian Wheatley Brinsfield</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>68</b>			2b. HOUR <b>8:50</b> M	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>11/2/1893</b>		6 AGE (In years last birthday) <b>74</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Wicomico</b> Md.	
10 CITY OR TOWN OF DEATH <b>Salisbury</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) <b>MARYLAND</b>			13b. COUNTY <b>DORCHESTER</b>		13c. CITY OR TOWN <b>GALESTOWN</b>		13d. RESIDE CITY, AM 15? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME First <b>ALBERT E.</b> Middle <b>WHEATLEY</b> Last <b>JONES</b>			15. MOTHER'S MAIDEN NAME First <b>JANE</b> Middle <b>JONES</b> Last <b>JONES</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>821-09-4592A</b>		17. INFORMANT Address <b>MRS. IMOGENE BRATTEN, PARSONSBURG, MD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) <b>arteriosclerotic heart disease</b>							<b>4-22</b>
DUE TO, OR AS A CONSEQUENCE OF							
(c) <b>generalized arteriosclerosis</b>							<b>4-22</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
<b>4-22 Diabetes, leukitis, cardiac decompensation</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>66</b> , to <b>April</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>April 19</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John E. Buckley M.D.</b> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/22/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GALESTOWN</b>		23d. LOCATION (City or Town) (County) (State) <b>GALESTOWN, MD</b>	
24. FUNERAL DIRECTOR <b>NEWNAM FUNERAL HOME, SHARPTOWN, MD</b> ADDRESS				25a. REC'D BY REGISTRAR <b>APR 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



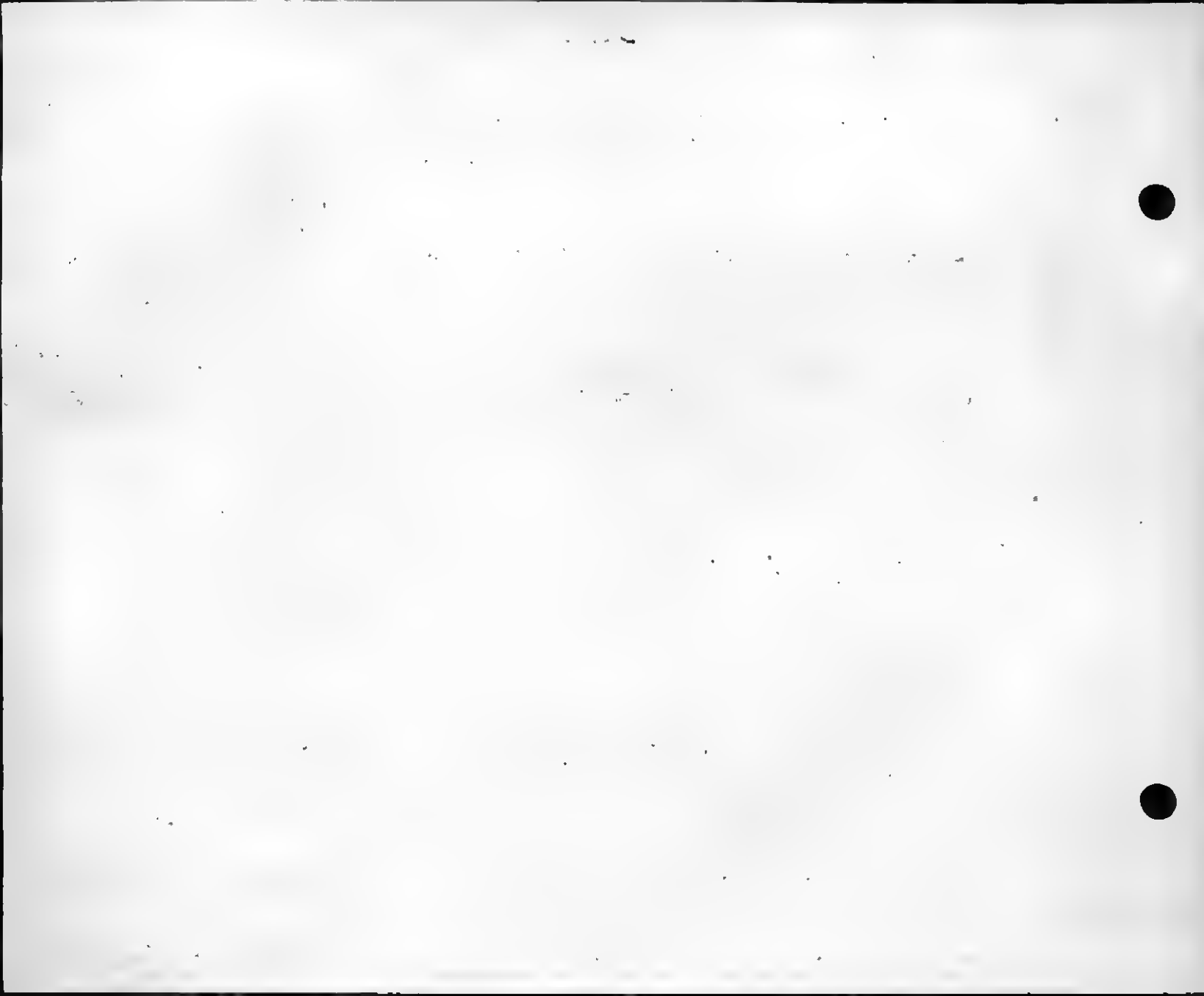
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <i>Benjamin</i> <b>FRANKLIN</b> <i>Brittingham</i>			2a. DATE OF DEATH Month <i>April</i> Day <i>19</i> Year <i>1968</i> P.M.			2b. HOUR	
3 SEX <i>Male</i>		4 RACE <i>White</i>		5. DATE OF BIRTH <i>August 18, 1905</i>		6 AGE (In years last birthday) <i>62</i> YRS	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Wicomico</i> Md.	
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired Manager Telegraph Co.</i>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Wicomico</i>		13c CITY OR TOWN <i>Salisbury</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <i>John W. Brittingham</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Nettie Fisher</i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>			
16b SOCIAL SECURITY NO. <i>214-07-7043</i>		17 INFORMANT (Wife) Address <i>Mrs. Delta G. Brittingham, Salisbury, Maryland</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Interarterio-sclerotic Heart Disease</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>4200</i> DUE TO, OR AS A CONSEQUENCE OF <i>4200</i> (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Cerebral Thrombosis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>April 18, 1968</i> to <i>April 19, 1968</i> , that (I) (we) last saw the deceased alive on <i>April 19, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <i>David J. Gilmore</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>April 20, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>Dr. David J. Gilmore</i>				22e. ADDRESS <i>Medical Center, Salisbury, Maryland</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b DATE <i>April 22, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parsons Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Salisbury, Wicomico, Maryland</i>	
24 FUNERAL DIRECTOR <i>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</i>				25a. RECD BY REGISTRAR DATE <i>APR 23 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION



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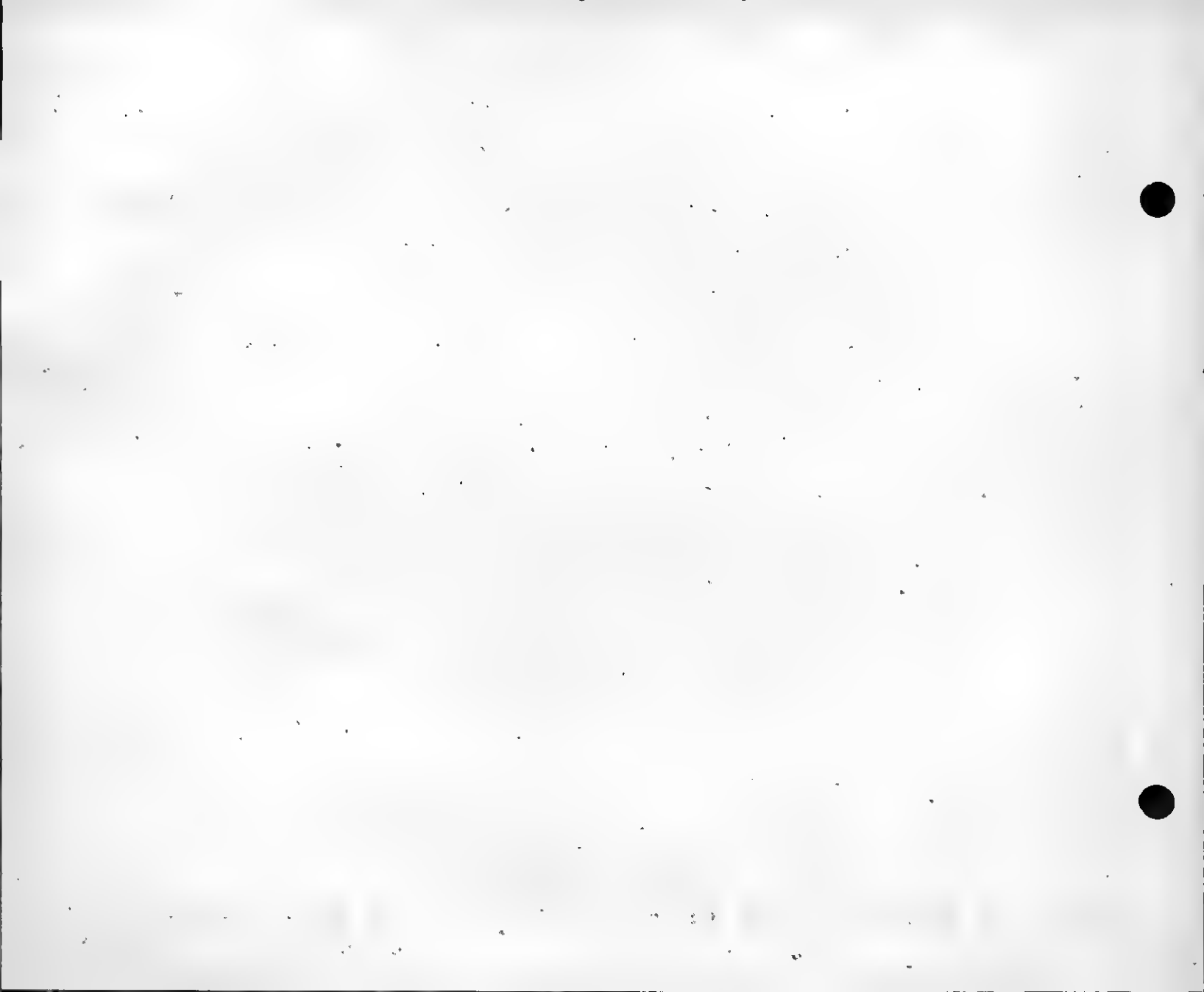
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VR-105 (10-60)  
30M REV. 11-60

4 1  
00314  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last ANNIE BROOKS			2a. DATE OF DEATH Month Day Year APRIL 26 1968			2b. HOUR 1:30 P.M.	
3. SEX FEMALE		4. RACE Negro		5. DATE OF BIRTH 9-25-84		6. AGE (In years lost birthday) 83 YRS	
7a. BIRTHPLACE (State or foreign country) Wicomico Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY Wicomico		13c. CITY OR TOWN FRUITLAND		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last WILLIAM GALE		15. MOTHER'S MAIDEN NAME First Middle Last EMMA HAYMAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO.		17. INFORMANT Address Randolph Brooks Box 223 Fruitland, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 3320							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH A few days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension arterial.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4/25, 1968, to 4/26, 1968, that (I) (we) last saw the deceased alive on 4/26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David J. Williams				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4-30-68		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City or Town) (County) (State) FRUITLAND WICO. MD.	
24. FUNERAL DIRECTOR Louise B. Jolley				ADDRESS P.O. Box 2 Salisbury Md.		25a. REC'D BY REG STRAB DATE MAY 01 1968	
				25b. REGISTRAR'S SIGNATURE Richard Judge			

MEDICAL CERTIFICATION



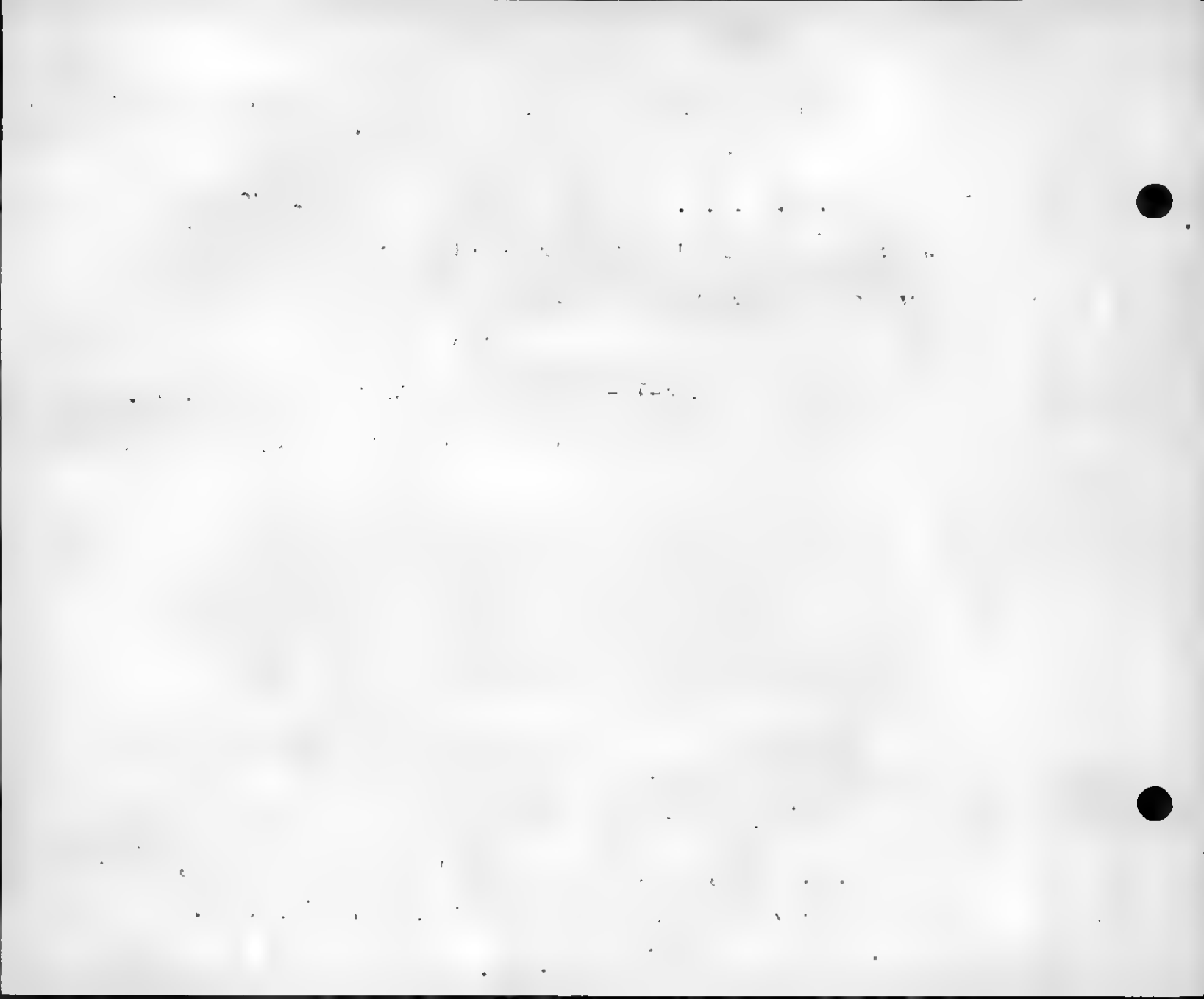


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 5 & 6 Film 6399  
4/15/68 kk 00113  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last <b>ORPHA LILLIAN BROSEY</b>			2a. DATE OF DEATH Month Day Year <b>April 2 1968</b>		2b. HOUR <b>1:05A M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>August 29, 1914</b>		6. AGE (In years lost birthday) <b>53</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>LEBANON CO. PA. U.A.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.A.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>WICOMICO</b> Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Deer's Head State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Somerset</b>	13c. CITY OR TOWN <b>Westover</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last <b>EDWARD REAM</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNA SMITH</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>183-17-5236</b>	17. INFORMANT Address <b>WALTER BROSEY WESTOVER, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of left breast with metastasis</b> <b>174X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>174X</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (A) (this hospital) attended the deceased from <b>March 27, 1968</b> to <b>April 2, 1968</b> , that (U) (we) last saw the deceased alive on <b>April 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (U) (we) (did) (do not) view the body after death.					
22b. SIGNATURE <b>W. V. Maldve, M. D.</b>				22c. DATE SIGNED <b>4/2/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22e. ADDRESS <b>Deer's Head State Hospital, Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4/4/1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CHIQUE'S HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>MANHEIM, PA.</b>	
24. FUNERAL DIRECTOR <b>LEVIN R. WILSON PRINCESS ANNE, MD.</b>			25a. REC'D BY REGISTRAR <b>APR 9 - 1968</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>



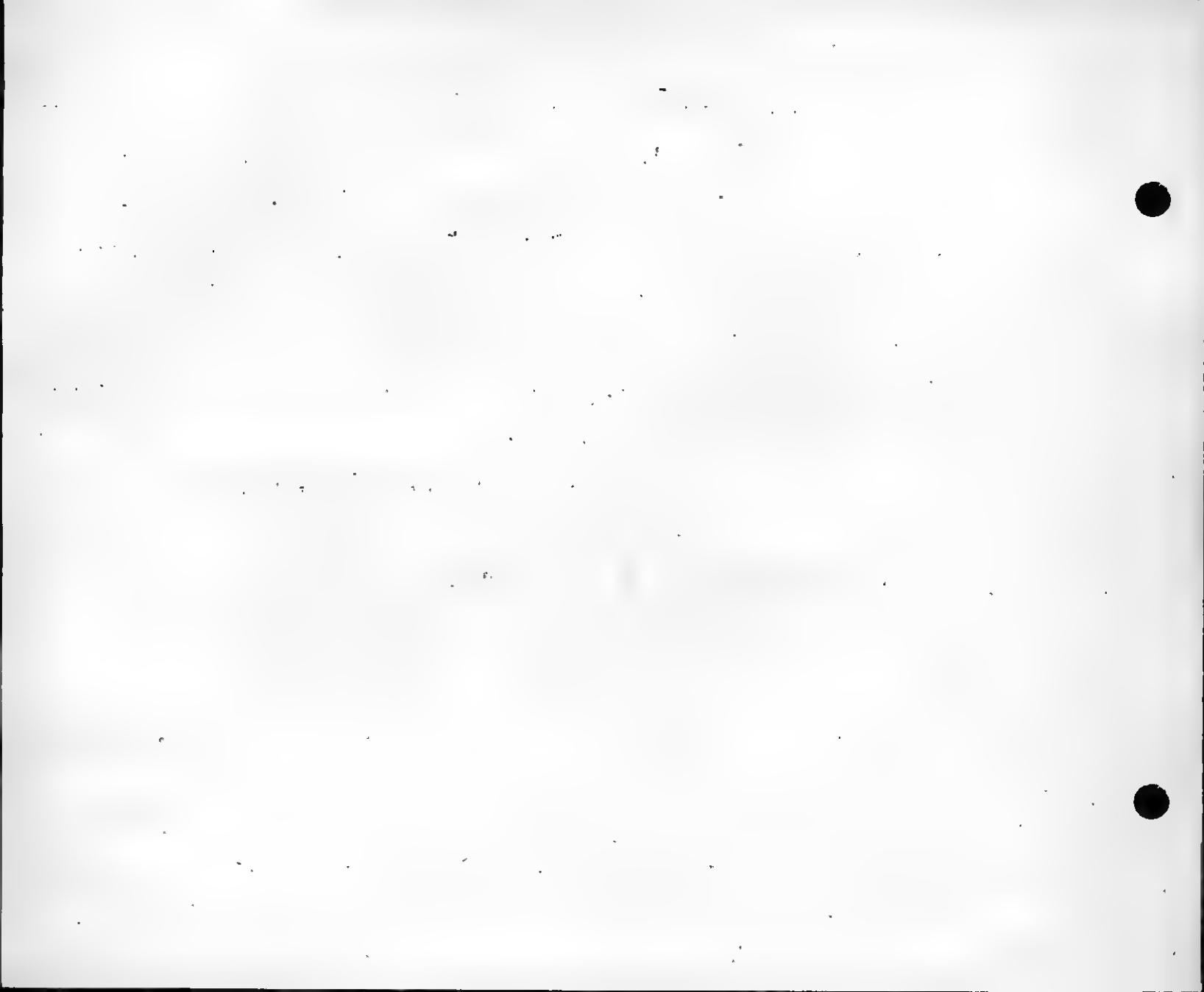
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MD 216  
MAY 1968  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>LARRY WASHINGTON BRUMBLEY</b>			2a. DATE OF DEATH <b>4</b> Month <b>19</b> Day <b>6</b> Year		2b. HOUR <b>3:15 P.M.</b>	
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH <b>5-7-01</b>		6. AGE (In years last birthday) <b>66</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WICOMICO NURSING HOME POOTH ST. SALISBURY, MD.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired-Attendant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN <b>Hebron</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>Church Street</b>	
14. FATHER'S NAME First Middle Last <b>George W. Brumbley</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Rosa Georgia Dryden</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes War II</b>		16b. SOCIAL SECURITY NO. <b>212-12-3549</b>	17. INFORMANT (Nephew) <b>Mr. Orville J. Riggan, Snow Hill, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>4120</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>++</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ca of head of pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertensive CVD</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Ca of head of pancreas</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>4/11</b> , 19 <b>68</b> , to <b>4/19</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/19</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Charles Beegley III MD</b> DEGREE				22c. DATE SIGNED <b>4/20/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>CHARLES BEEGLEY III</b>				22e. ADDRESS <b>Salisbury, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 23, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		23d. LOCATION (City or Town) (County) (State) <b>Worcester Co., Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 24 1968</b>		
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



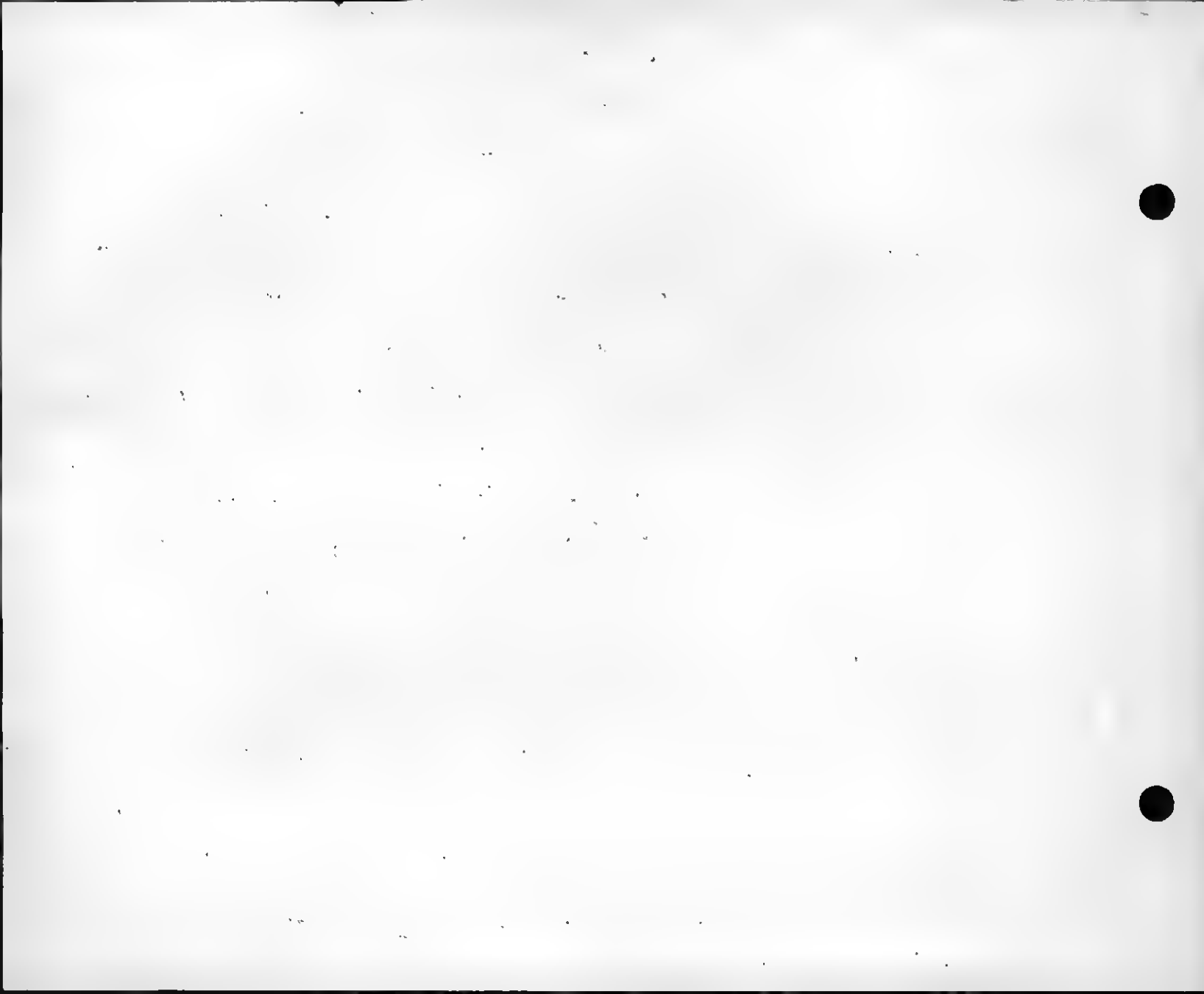
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 2, and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR 110 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>LLOYD WASHINGTON BURKE</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1968</b>			2b. HOUR <b>P</b> MIN <b>2:35</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>April 28, 1903</b>		6. AGE (In years lost birthday) <b>64</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>WICOMICO</b> Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Farmer</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>R.D.#3</b>		14. FATHER'S NAME First <b>George</b> Middle <b>Burke</b> Last <b>George</b>		15 MOTHER'S MAIDEN NAME First <b>Joanna</b> Middle <b>FRUITT</b> Last <b>FRUITT</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT (Wife) Address <b>R.D.#3</b> <b>Mrs. Minnie L. Burke, Salisbury, Maryland</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ASBESTOSIS &amp; Failure</b> <b>412.0</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension, arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pharyngeal Hypertrophy &amp; Aspiration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>444x</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/12/68</b> , 19 <b>68</b> , to <b>4/18/68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/15/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dr. Carrie I. Hearn</b> MD		22c. DATE SIGNED <b>April 19/1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Dr. Carrie I. Hearn</b>		22e. ADDRESS <b>226 N. Division St., Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 21, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wango Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wango Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. RECORD REGISTRAR <b>APR 23 1968</b>		25b. REGISTERED DEATH <b>Judge</b>			





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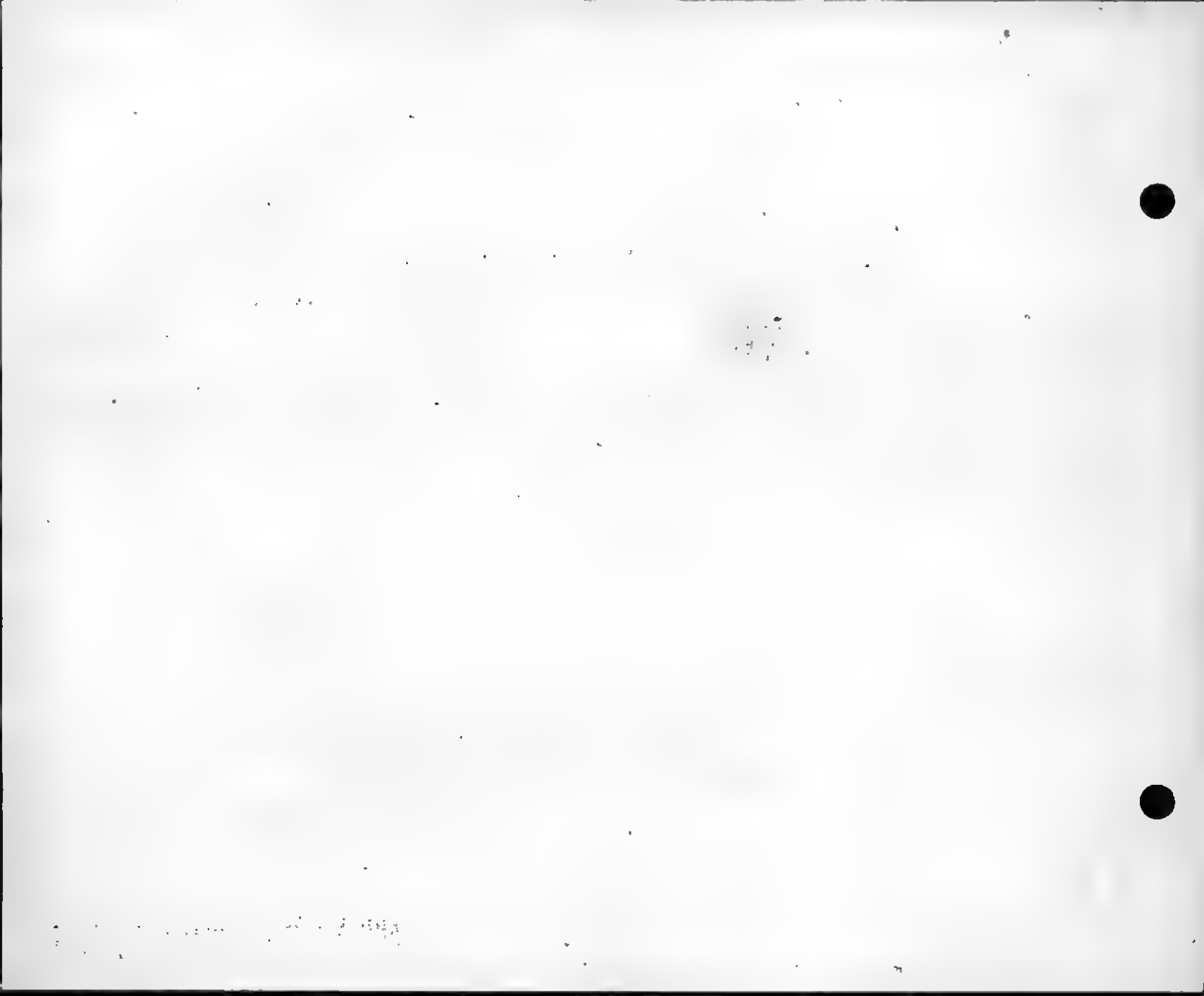
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VR A15 (4)  
304 REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <sup>First</sup> <u>JOHN</u> <sup>Middle</sup> <u>ELMER</u> <sup>Last</sup> <u>BUTLER</u>			2a. DATE OF DEATH <sup>Month</sup> <u>APRIL</u> <sup>Day</sup> <u>7</u> <sup>Year</sup> <u>1968</u>		2b. HOUR <u>2:15</u> <sup>PM</sup> <u>AM</u>	
3 SEX <u>MALE</u>	4 RACE <u>Negro</u>	5 DATE OF BIRTH <u>9-12-17</u>		6 AGE (In years last birthday) <u>50</u> YRS.	IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>	IF UNDER 24 HRS. HOURS <u>0</u> MIN <u>0</u>
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>Wicomico</u> Md.			
10 CITY OR TOWN OF DEATH <u>Salisbury</u>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Peninsula General Hospital</u>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Labor</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) <u>MARYLAND</u> STATE	13b. COUNTY <u>Wicomico</u>	13c. CITY OR TOWN <u>SALISBURY</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <u>R.F.D. 2</u>		
14 FATHER'S NAME <sup>First</sup> <u>John F.</u> <sup>Middle</sup> <u>Butler</u> <sup>Last</sup>		15. MOTHER'S MAIDEN NAME <sup>First</sup> <u>Mildred</u> <sup>Middle</sup> <u>?</u> <sup>Last</sup> <u>Green</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates at service)		16b. SOCIAL SECURITY NO <u>217-02-9369</u>	17. INFORMANT <u>Jacqueline Butler Wentico Md.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> <u>177</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastasis to liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>157x</u>						
19a. DATE OF OPERATION <u>3/21 &amp; 3/26</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Ca of pancreas + Wound dehiscence</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY <u>4</u> HOUR A.M. <u>19</u> Month <u>4</u> Day <u>6</u> Year <u>1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED <u>at work</u> <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No <u>311</u> City or Town <u>Salisbury</u> County <u>Wicomico</u> State <u>Md.</u>		
22a. I certify that (I) (this hospital) attended the deceased from <u>3/11/68</u> 19 <u>68</u> , to <u>4/6/68</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/6/68</u> 19 <u>68</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did not) view the body after death.						
22b. SIGNATURE <u>Robert M. Beazley MD</u> DEGREE <u>MD</u> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>				22c. DATE SIGNED <u>4/7/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>Robt. M. BEAZLEY</u>		22e. ADDRESS <u>PENINSULA GEN'L Hosp.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>4/13/1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Calvary</u>	23d. LOCATION (City or Town) <u>Baltimore</u> (County) <u>Wicomico</u> (State) <u>Md.</u>	25a. REC'D BY REGISTRAR <u>Charles J. Jones</u> DATE <u>APR 16 1968</u>		
24. FUNERAL DIRECTOR <u>Clinton L. Stevens of Salis Md</u> ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>				

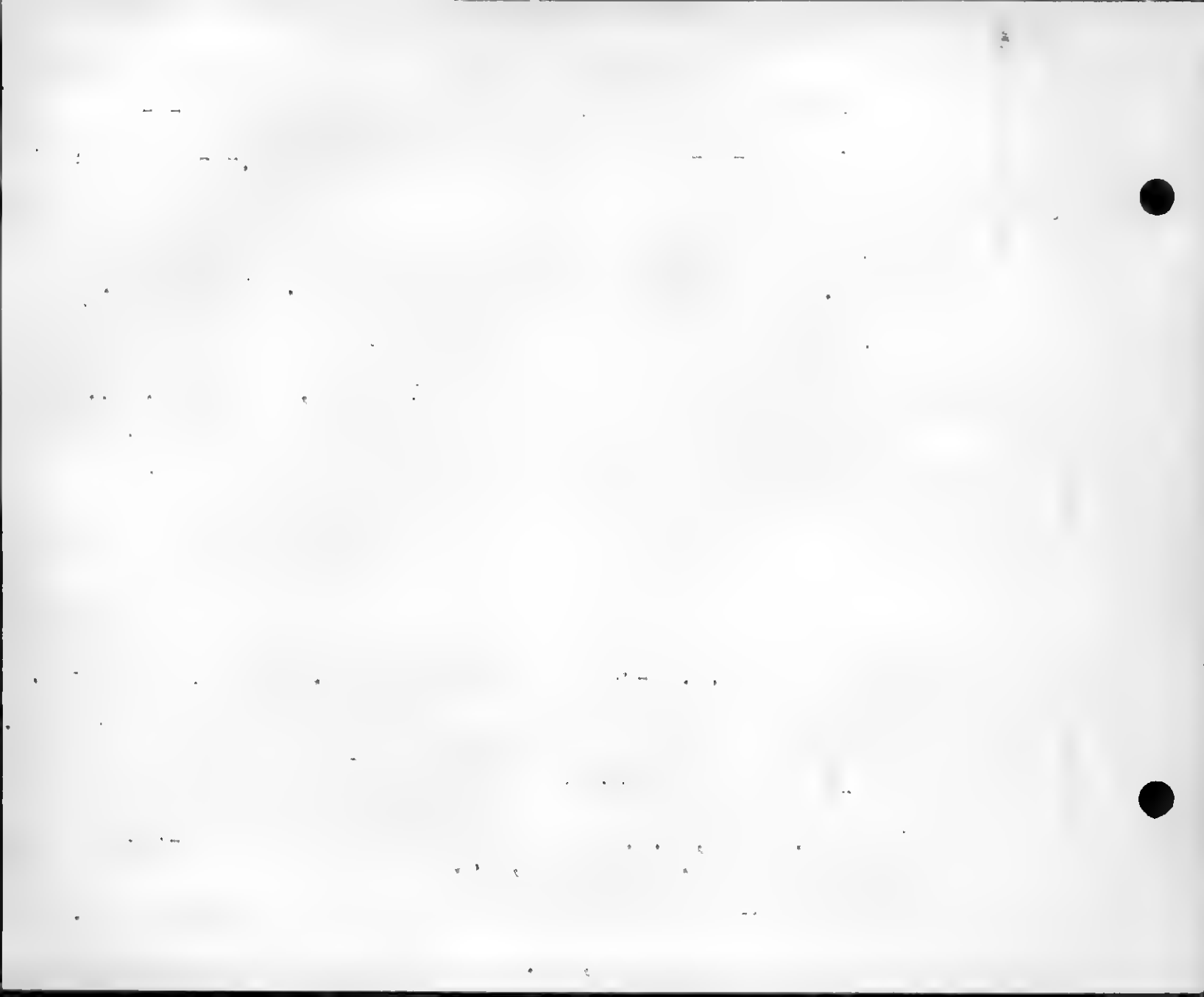


FOR STATE  
HEALTH DEPT.

TO DEPUTY CLERK EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 7a, 7b, & 8  
Film G399 4/18/68  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) First Middle Last <b>Donald Lee Christopher</b>			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year <b>4-9-68</b> 19 <b>M</b>	
3 SEX <b>M</b>	4 RACE <b>C</b>	5. DATE OF BIRTH <b>12-27-52</b>	6. AGE (In years last birthday) <b>15</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month Day Year <b>4-9-68</b> 19 <b>3:30 P M</b>
7a. BIRTHPLACE (State or foreign country) <b>Wicomico Co., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. COUNTY OF DEATH <b>Wicomico</b> Md
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>County Dump</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Student</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Fruitland</b>
14. FATHER'S NAME First Middle Last <b>James Christopher</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Irene Hutt</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT <b>Irene Christopher, Fruitland, Md.</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Sudden</b>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>992.8</b>				
19a. DATE OF OPERATION <b>4-9-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>P.M. 4-9-68</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fell into 12 ft. hole full of water.</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>County Dump</b>		21f. LOCATION Street or R.F.D. No. City or Town County - State <b>Salisbury Wicomico Md.</b>
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>4-10-68</b>
EXAMINER'S NAME (Type) <b>409 Camden Ave. Salisbury, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>4-13-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Flower Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Eden Somerset Md.</b>
24. FUNERAL DIRECTOR <b>West Funeral Home Salisbury, Md.</b>		25a. REC'D BY REG STRAR <b>APR 15 1968</b>		25b. REG STRAR'S SIGNATURE <b>Charles Judge</b>



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VR A15 (4)  
30M REV. 1/68

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last <b>Edward EMERSON Cooley</b>			2a. DATE OF DEATH Month Day Year <b>April 18 1968</b>			2b. HOUR <b>8:18 A M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 2, 1890</b>		6. AGE (In years lost birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital type street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Rug Co.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>504 S. Park Drive</b>	
14. FATHER'S NAME First Middle Last <b>John B. Cooley</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Clara Yardley</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service) <b>No</b>			
16b. SOCIAL SECURITY NO <b>166-07-7103</b>			17. INFORMANT (Daughter) <b>Mrs. Marguerite C. Tibbitt, Salisbury, Md.</b>			Address <b>504 S. Park Dr.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Decomposition</b> <b>4-18-68</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>General Arteriosclerosis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>125</b> <b>125</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4-18-68</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-18-68</b> , 19 <b>68</b> , to <b>4-18</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-18-68</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>J. T. Bulkeley, M.D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4-18-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. J. T. Bulkeley</b>				22e. ADDRESS <b>Pine Bluff Road, Salisbury, Maryland</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 20, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. James Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Philadelphia Pa.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>DATE APR 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

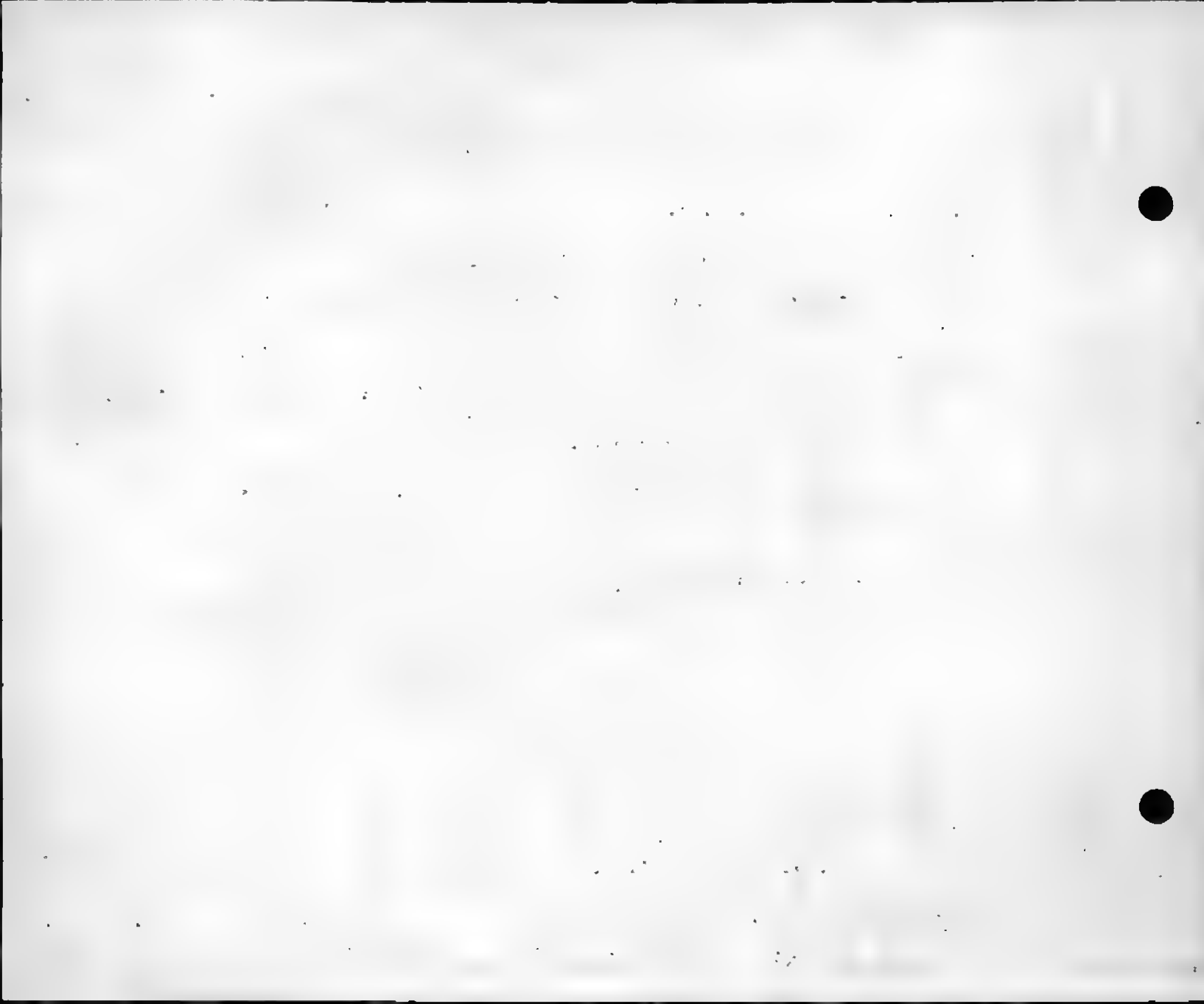


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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Heber			Coward			Apr. 20 1968			9:25 P		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		colored		3/23/14			54 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
N. Carolina		U. S. A.					Wicomico		Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					
Salisbury			Deer's Head State Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Wicomico		Mardela		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		P.O. Box 19		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Joe			Mary			William					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
					Floyd Coward			Mardela Springs Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident, left										3 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease										Years	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
42 Cerebral vascular accident - 6 months ago											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/5, 1968, to 4/20, 1968, that (I) (we) last saw the deceased alive on 4/20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								22c. DATE SIGNED			
A.C. Mitchell, MD								4/22/68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
A. C. Mitchell, M. D.						Deer's Head State Hospital, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
BURIAL			4-25-68		FREEWILL			Ayden Ayden NC.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Loretta E. Jolley						DATE MAY 01 1968		Charles Judge			

MEDICAL CERTIFICATE





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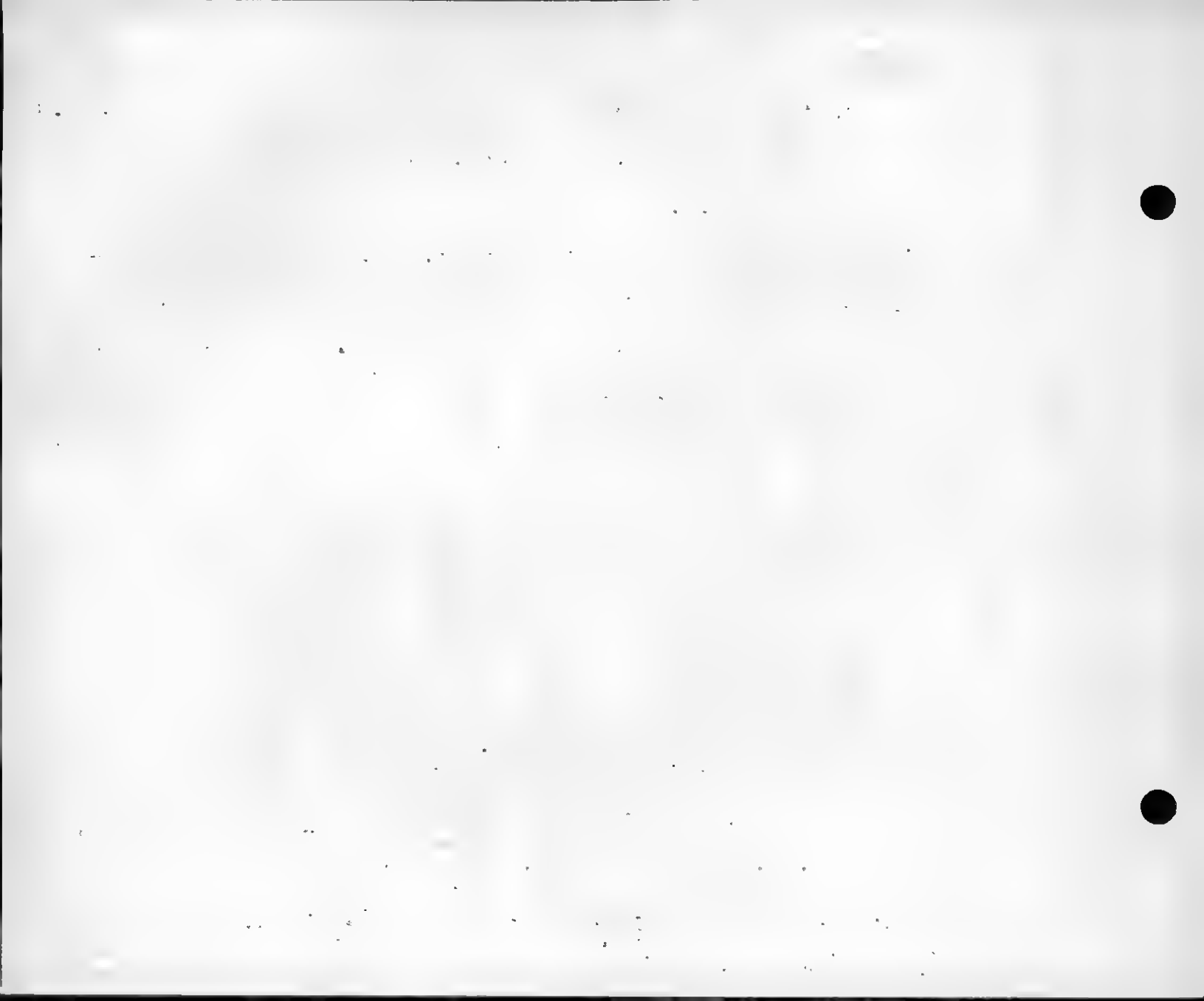
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR A.M. OR P.M.		
Julius Cecil Darden					April 18 1968		11:00		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male	Colored		Oct. 25, 1900		67 YRS.				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8- MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Georgia	U.S.A.				Wicomico Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Pine Bluff State Hosp.		Laborer					
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Talbot		Easton		YES <input type="checkbox"/> NO <input type="checkbox"/>		Dover Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Branch - Darden			Fannie - Jones						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No -		222-05-1626		Records of		Pine Bluff State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile degeneration</u> <u>794X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from Jan. 22, 1968, to April 18, 1968, that (X) (we) last saw the deceased alive on April 18, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death.									
22b. SIGNATURE <u>E. P. Ritchings</u>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 19, 1968			
22d. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.				22e. ADDRESS Pine Bluff State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 4-19-68		23c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Md</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Wicomico Md</u>			
23e. FUNERAL DIRECTOR <u>Brooks M. West</u>				25a. REC'D BY REGISTRAR DATE APR 22 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATE ON



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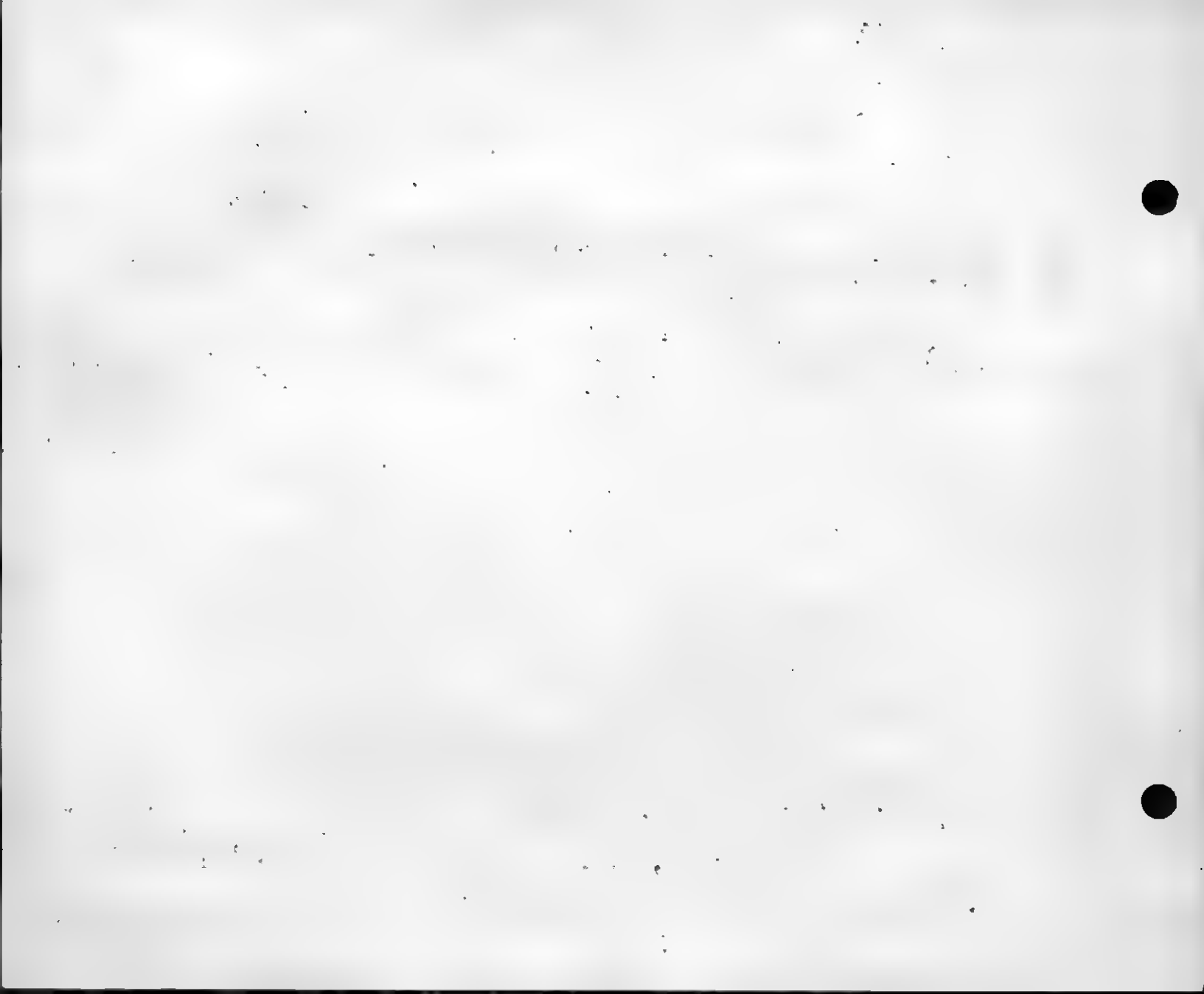
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VR 15-68  
304M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>John Henry DASHIELL</b>			2a. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>68</b>			2b. HOUR <b>3 55</b> AM	
3. SEX <b>Male</b>		4. RACE <b>Cal</b>		5. DATE OF BIRTH <b>Feb. 1919</b>		6. AGE (In years last birthday) <b>49</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Wicomico</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>laborer</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Salisbury</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Mardella</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME First <b>William Leo</b> Middle <b>Dashill</b> Last <b>Dashill</b>				15. MOTHER'S MAIDEN NAME First <b>Glossie</b> Middle <b>Blackmon</b> Last <b>Blackmon</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-229324</b>		17. INFORMANT <b>Glossie Blackmon</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACHALASIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ESOPHAGO COLON STRICTURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MALNUTRITION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>July 67</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION <b>3/10/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ESOPHAGO COLON STRICTURE</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/14</b> , 19 <b>68</b> , to <b>4/3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/3</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Martin E. Zipser, M.D.</b>		DEGREE <b>MD</b>		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>4/3/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Martin Zipser, M.D.</b>		22e. ADDRESS <b>Salisbury, Maryland Peninsula General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>4-5-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mardella Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Mardella Wicomico Md</b>	
24. FUNERAL DIRECTOR <b>Booker McWeed</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 9 - 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

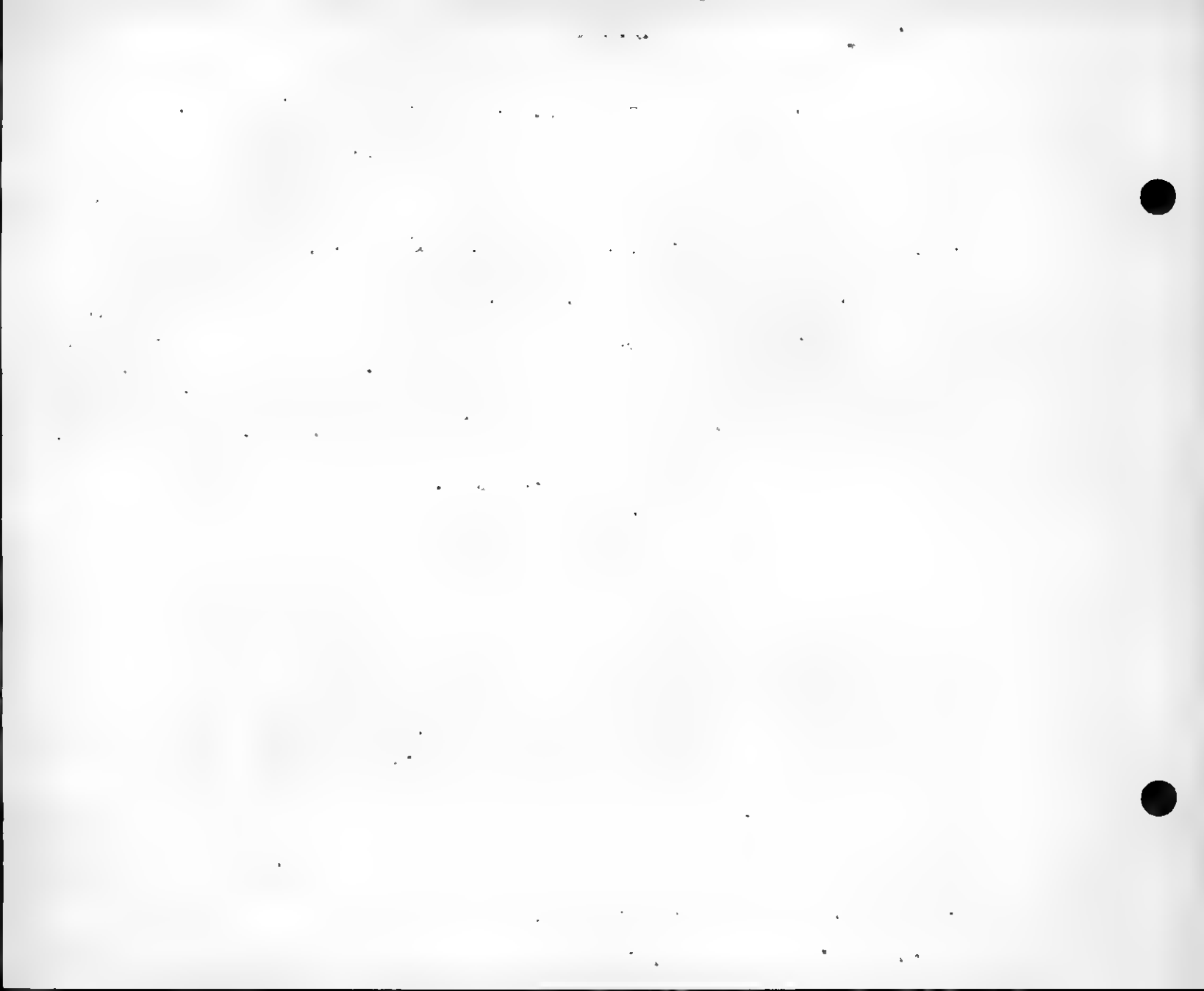
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>EUPHEMIA</b>		First	Middle	Last	2a. DATE OF DEATH Month <b>APRIL</b> Day <b>16</b> Year <b>68</b>		2b. HOUR M		
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>January 22, 1895</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS M.N.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b>			Md.
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during part of working life, even if retired) <b>Retired Shift Factory Employee</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>417 A. E. Vine Street</b>	
14. FATHER'S NAME First <b>Alexander</b> Middle <b>Green</b> Last <b>Green</b>				15. MOTHER'S MAIDEN NAME First <b>Della</b> Middle <b>Bloodsworth</b> Last <b>Bloodsworth</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) <b>Mrs. Mary Serman, Salisbury, Maryland</b>			Address <b>417A E. Vine St.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Arterial Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>Not Known</b> <b>Not Known</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <b>3/24/68</b> to <b>4/6/68</b> , that (I) (we) last saw the deceased alive on <b>4/5/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. O. J. Burton</b>				22c. ADDRESS <b>Medical Center, Salisbury, Maryland</b>		22d. DATE SIGNED <b>April 6, 1968</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 9, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Wicomico, Maryland</b>			
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>APR 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



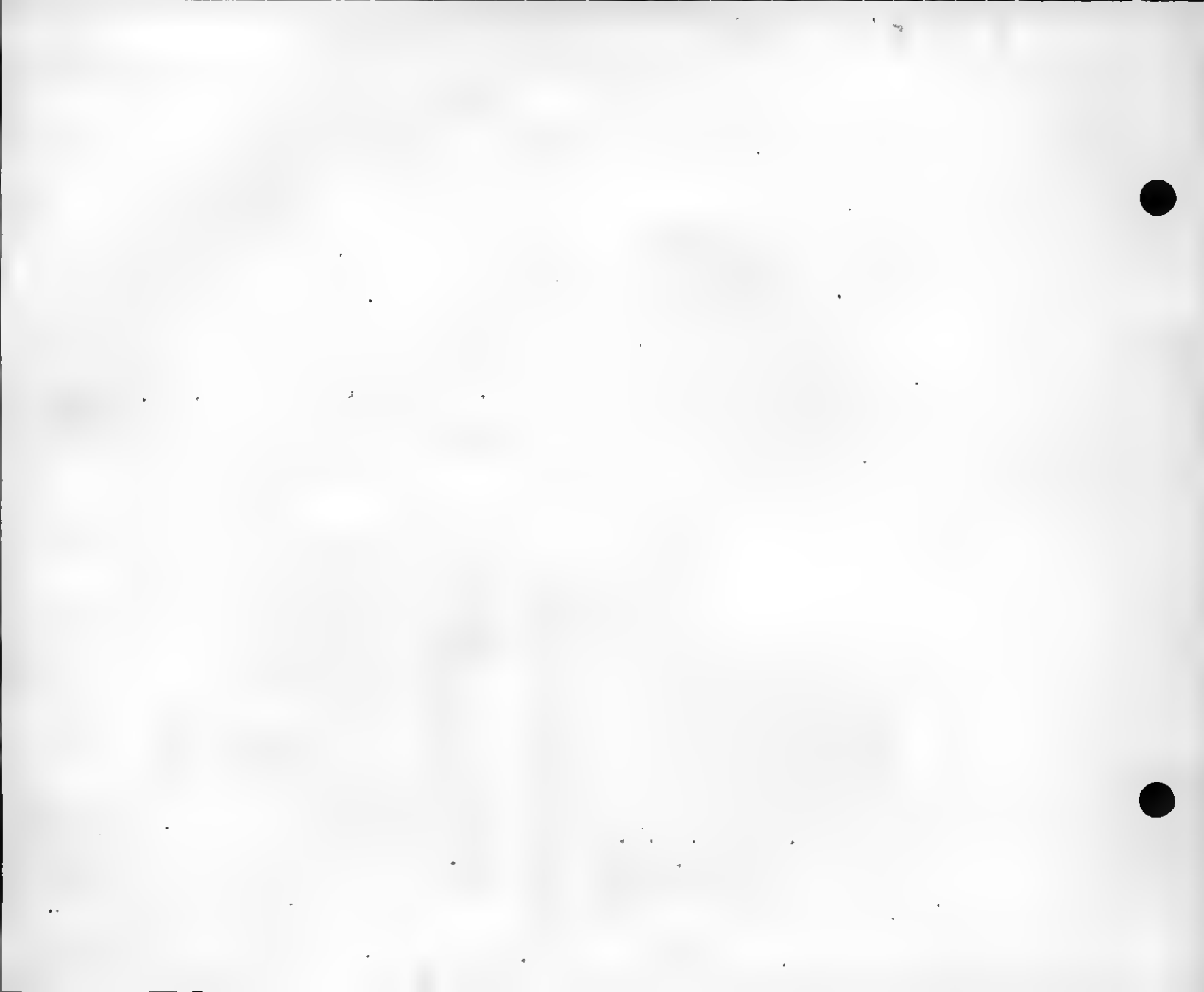
**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-13. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15MB 15  
10M REV 1068

10-225 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
ROBERT		ASBURY		DAVIS				2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years and birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		2d. HOUR	
M		W		6-19-1882		85 YRS.		MONTHS		DAYS		2c. DATE PRONOUNCED DEAD		Month		2d. HOUR	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH											
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Wicomico											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUA. OCCUPATION (Kind of work done during most of working life even if retired)		12b. KIND OF BUSINESS OR INDUSTRY											
Salisbury		Peninsula General		Ret. Farmer		Own Farm											
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Md.		Wicomico		Willards		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RED									
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
RANK		Lemuel James Davis						Rhoda Lewis									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS											
XX		XX		Mrs. Ray Lewis Willards, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> 569.7 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: _____ hours																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 578x																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED		April 4, 1968											
Earl L. Royer, M.D.		409 Camden Ave., Salisbury, Md.															
23a. BURIAL, CREMATION, or other disposal		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
Burial		4/8/68		Truitt		Willards Wicomico Md.											
24. FUNERAL DIRECTOR		25a. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Watson & Whaley, Selbyville, Del.		Ark 9 - 1968		Charles Judas													





FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
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00326

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH MATED		Month		Day		Year		2b HOUR													
JOHN		RUSSELL		DENNIS				4-29-68		19		3		P		M													
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years lost to day)		F UNDER 1 YEAR		F UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year		2d HOUR											
M	AA	2-3-22		46 YRS.		MONTHS		DAYS		HOURS		MIN		4		29		1968											
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9 COUNTY OF DEATH																					
Md.		U.S.		WIDOWED		DIVORCED		Wicomico																					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY																							
Salisbury		Peninsula General																											
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		32 INSIDE CITY LIMITS?		13e STREET AND NUMBER																					
Md.		Somerset		Princess Anne		YES		307 Hampton Ave.																					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last															
ISAAC		DENNIS						EMMA		WILKINS																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS																							
No				EMMA MCCLASE-PRINCESS ANNE																									
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rupture of esophagus																34 days													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																													
(b) DUE TO, OR AS A CONSEQUENCE OF																													
(c) DUE TO, OR AS A CONSEQUENCE OF																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?																	
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																					
				3-26-68				Crushed beneath ice at processing plant.																					
21a INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21b PLACE OF INJURY (At home, farm, street, factory, office building, etc)				21c LOCATION Street or R.F.D. No																					
				Perdue Processing Plant				Salisbury, Wico., Md.																					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER						22b. DATE SIGNED																	
Earl L. Royer, M.D.												April 30, 1968																	
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER						ADDRESS (Street, city, town, or county)																	
409 Camden Ave. Salisbury, Md.																													
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town)				(County)				(State)									
BURIAL				5/4/68				EBENEZER CEM.				MARUMSCO				Md.													
24 FUNERAL DIRECTOR												ADDRESS						25a REC'D BY REG STRAR						25b REGISTRAR'S SIGNATURE					
Anthony Ward Funeral Home, Crisfield, Md.												MAY 3 1968						Charles Judge											

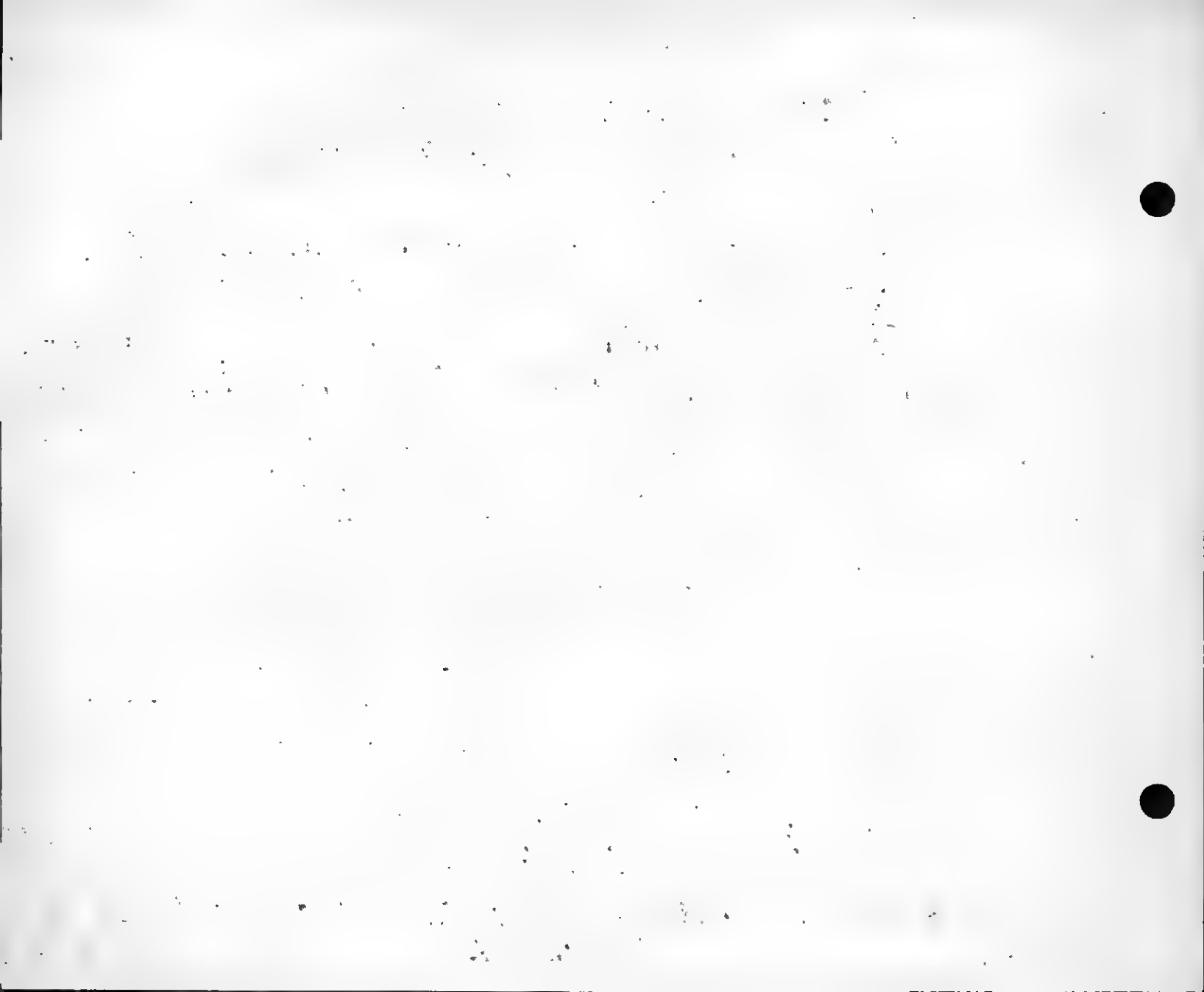


MDARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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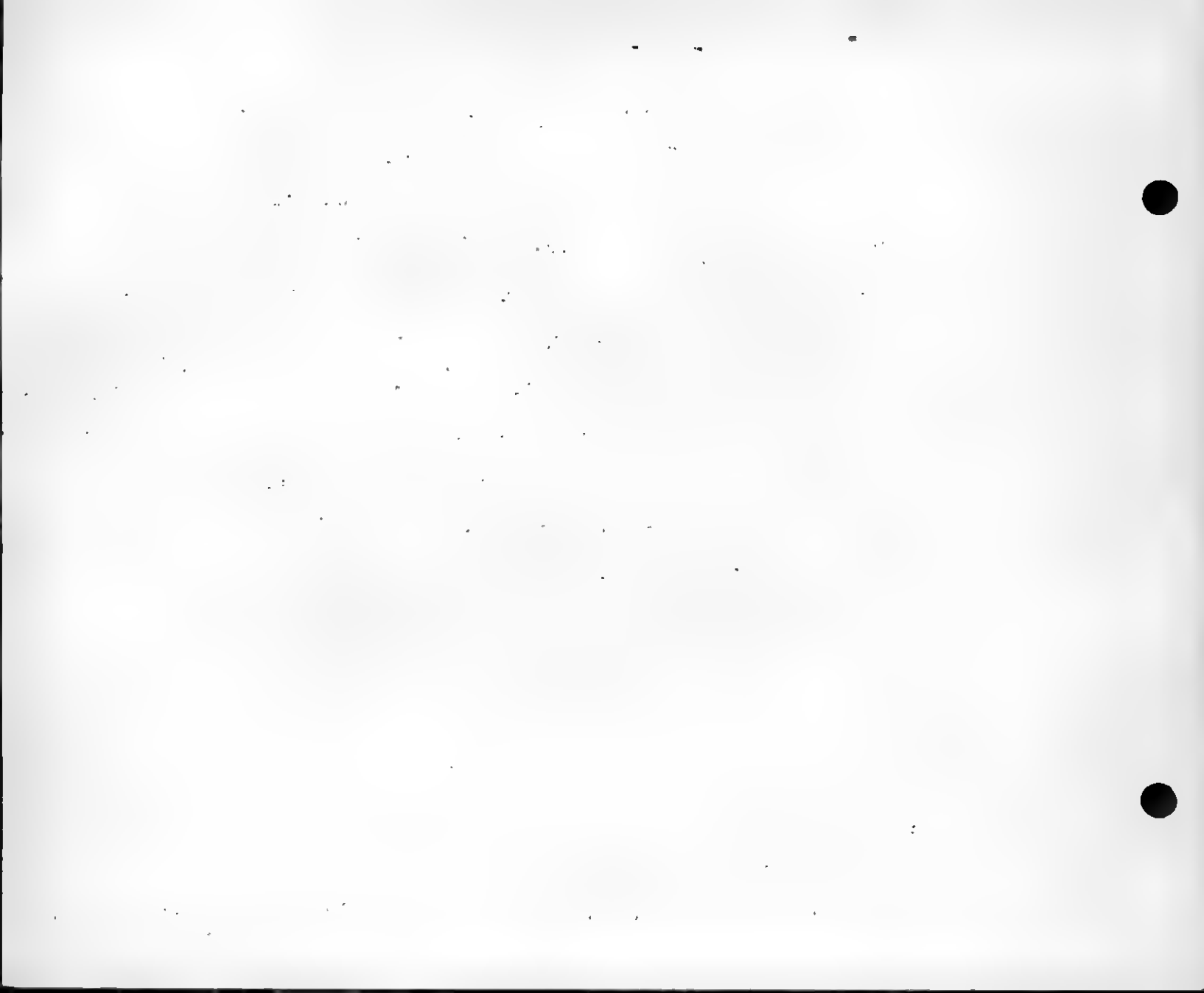
1. DECEASED NAME (Type or print) <b>Mary Emma Downing</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>68</b>			2b. HOUR <b>1:15</b> AM	
3 SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>Mar. 24, 1903</b>		6. AGE (In years lost birthday) <b>65</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Factory</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Va.</b>		13b. CITY OR TOWN <b>Accomack Horn-town</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Box 55</b>	
14. FATHER'S NAME First Middle Last <b>John Smith</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma Sample</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, in ( ) Unknown ( ) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>229-36-4717A</b>		17. INFORMANT Address <b>Wm. Downing Horn-town, Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Disease</b> <b>44-1</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost: <b>4500</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Unk.</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Fatty Infiltration of Liver; Diabetic Ketoacidosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b> NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Apr. 26, 1968</b> to <b>April 28, 1968</b> that (I) (we) last saw the deceased alive on <b>April 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Herbert Sembly MD</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>4/29/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>G. Herbert Sembly</b>				22e. ADDRESS <b>Salisbury, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>May 5, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Haskell Ruth Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Accomack Accomack Va.</b>	
24. FUNERAL DIRECTOR <b>Samuel Sany</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
VERNON HARTSWELL			English			Month Day Year			5 54 AM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. FUNERAL YEAR		8. IF UNDER 24 HRS			
Male		White		July 20, 1903			64 YRS.		MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland			USA						Wicomico			Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital			none								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Wicomico			Salisbury			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			111 E. William Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
Charles Sherman English			Stella B. Venables											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No			---			(Sister)			900 Irvington Road					
						Mrs. Martha A. Engberg, Chester, Pennsylvania								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>coronary occlusion</u>														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>chronic intractable congestive failure</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
			19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>April 10, 1968</u> to <u>April 20, 1968</u> , that (I) (we) lost the deceased on <u>April 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED											
Dr. John T. Bulkeley M.D.			4-20-68											
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS											
Dr. John T. Bulkeley			Salisbury, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			April 23, 1968			Mardela Memorial Cemetery			Mardela, Wicomico, Md.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						DATE APR 24 1968			Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
Item 6 Film G400														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Elsie J.			EsKridge			April Month Day Year 12 68			1 49 AM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
F.		C.		4/11/1909			68 59 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland			U.S.A.						Wicomico			Md.		
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury				Peninsula General Hospital				Domestic						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TSP		13e. STREET AND NUMBER				
Md.				Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		620 Isabella St.				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME										
First Middle Last				First Middle Last										
George Dashields				Sarah Dashields										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.				17. INFORMANT				Address		
NO								Joseph EsKridge				Salisbury Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Meningitis (pneumococcal)											4 1/2 days			
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF														
(b)														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
2751														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
			HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION								
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>						Street or R.F.D. No City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 4-11-68, 1968, to 4-12-68, 1968, that (I) (we) last saw the deceased alive on 4-12-68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE											22c. DATE SIGNED			
John S. Bulkeley, M.D.											22 18 68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)						
Burial			4/15/1968		Church			Columbus Sussex Md.						
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Clinton E. Stewart						DATE APR 22 1968			Richard Judge					



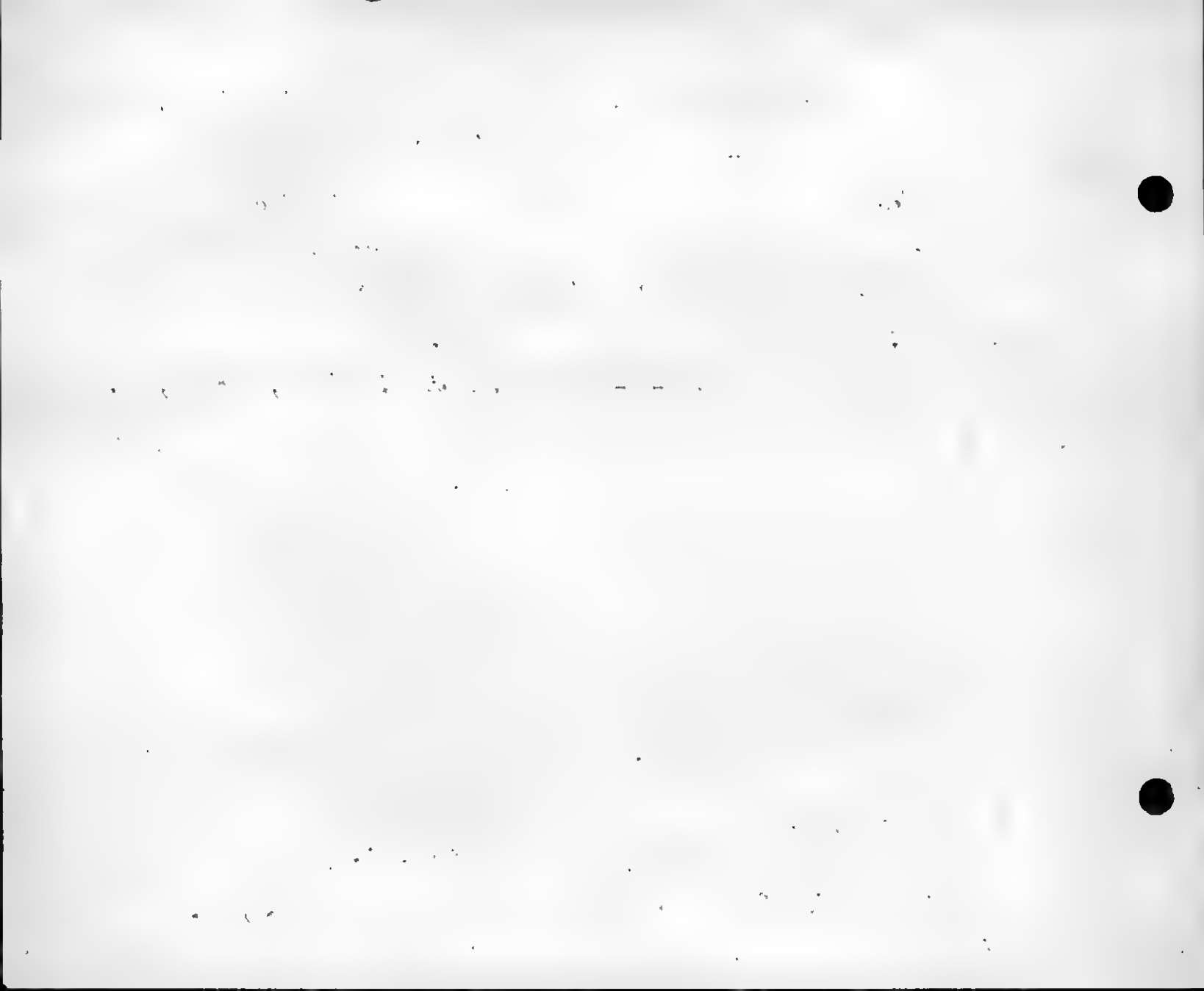


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VA 11-10  
30M REV. 11-68

<div style="text-align: center;"> <p>00330</p> <p>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> <p><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">J6336</p> </div>											
1. DECEASED-NAME (Type or print) <i>Bentha Jane Fletcher</i>						2a. DATE OF DEATH 4 Month 4 Day 1968			2b. HOUR 3 A. M.		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>1/9/1890</i>			6. AGE (In years last birthday) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M N
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.					
10. CITY OR TOWN OF DEATH <i>Mardela</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>RFD</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housework</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Mardela</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>RFD</i>		
14. FATHER'S NAME First Middle Last <i>Unkn.</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Unkn.</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO <i>215-07-78290</i>		17. INFORMANT Address <i>Mrs. Sadie L. Gilbert, Mardela, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Lesion</i> <i>5/1/9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <i>34 years</i> <i>10 years</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>581.0</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1958</i> , to <i>April 4, 1968</i> , that (I) (we) lost the deceased on <i>4/4/68</i> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>H. J. Kuhlman</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/6/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>H. J. Kuhlman</i>						22e. ADDRESS <i>Wicomico, Md.</i>					
23a. BURIAL, CREMATION, or other disposal (Specify) <i>Buried</i>		23b. DATE <i>4/7/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mardela</i>		23d. LOCATION (City or Town) <i>Mardela, Md.</i>		(County)		(State)	
24. FUNERAL DIRECTOR <i>Newman Funeral Home</i>						ADDRESS <i>Shopton, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>APR 9 - 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



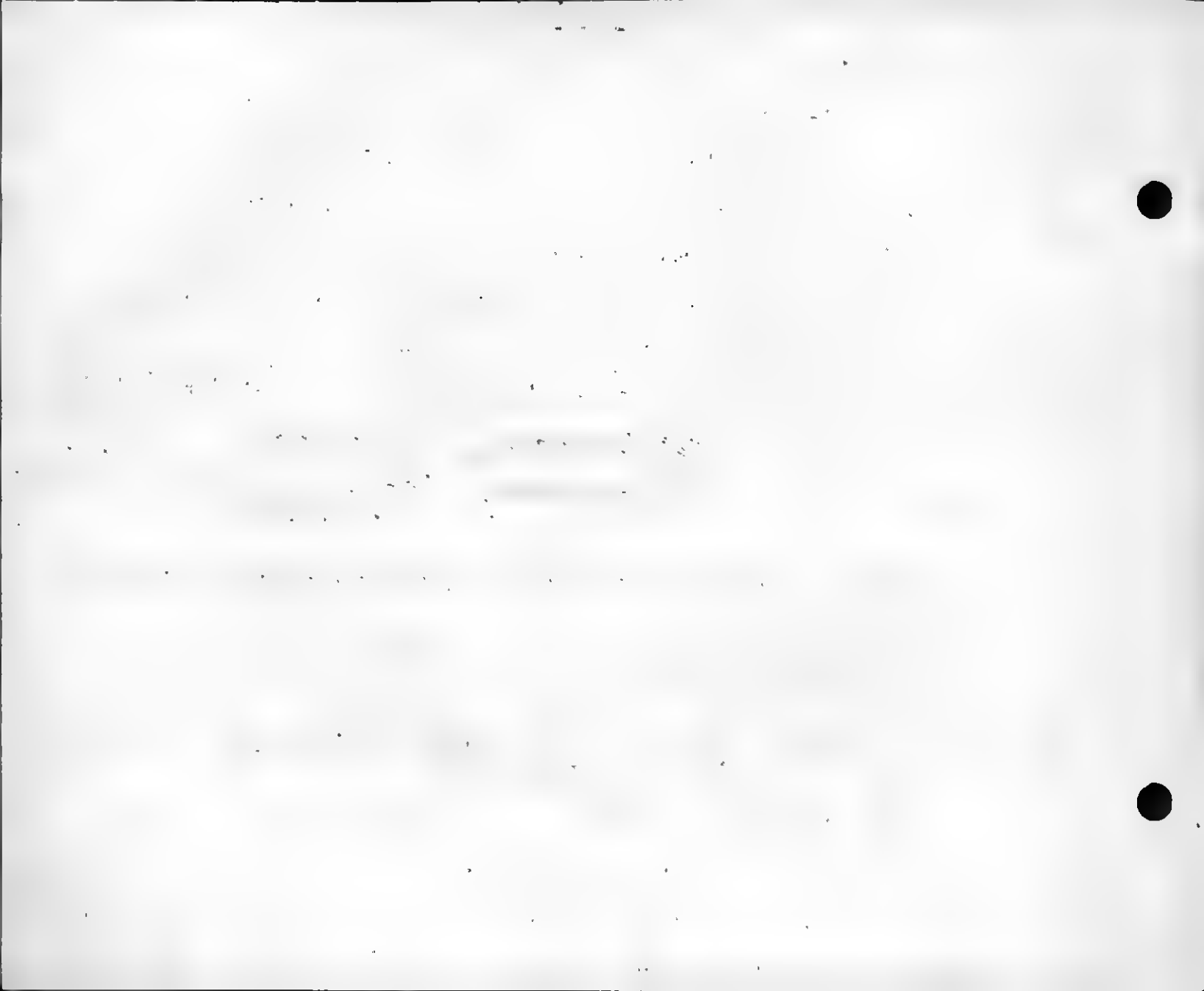
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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) First Middle Last <b>WILLIAM LEE GERMAN</b>			2a. DATE OF DEATH Month Day Year <b>April 27 1968</b>		2b. HOUR <b>7:59 A.M.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>April 24, 1892</b>		6. AGE (In years last birthday) <b>76</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>WICOMICO</b> Md.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>111 Brooklyn Avenue</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Auto Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN <b>Salisbury</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>111 Brooklyn Avenue</b>	
14. FATHER'S NAME First Middle Last <b>Washington German</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Foskey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>182-18-2072</b>	17. INFORMANT (Wife) <b>Mrs. Elise L. German, Salisbury, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>163x</b> (b) <b>Pulmonary Carcinoma with metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>urinary tract infection, acute urinary retention</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from <b>1967</b> , 19 <b>67</b> , to <b>4/27</b> , 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>4/27</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Alberta Polin MD</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>April 29/1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. Alberta Polin</b>		22e. ADDRESS <b>707 Camden Ave., Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 29, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Wicomico, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>APR 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

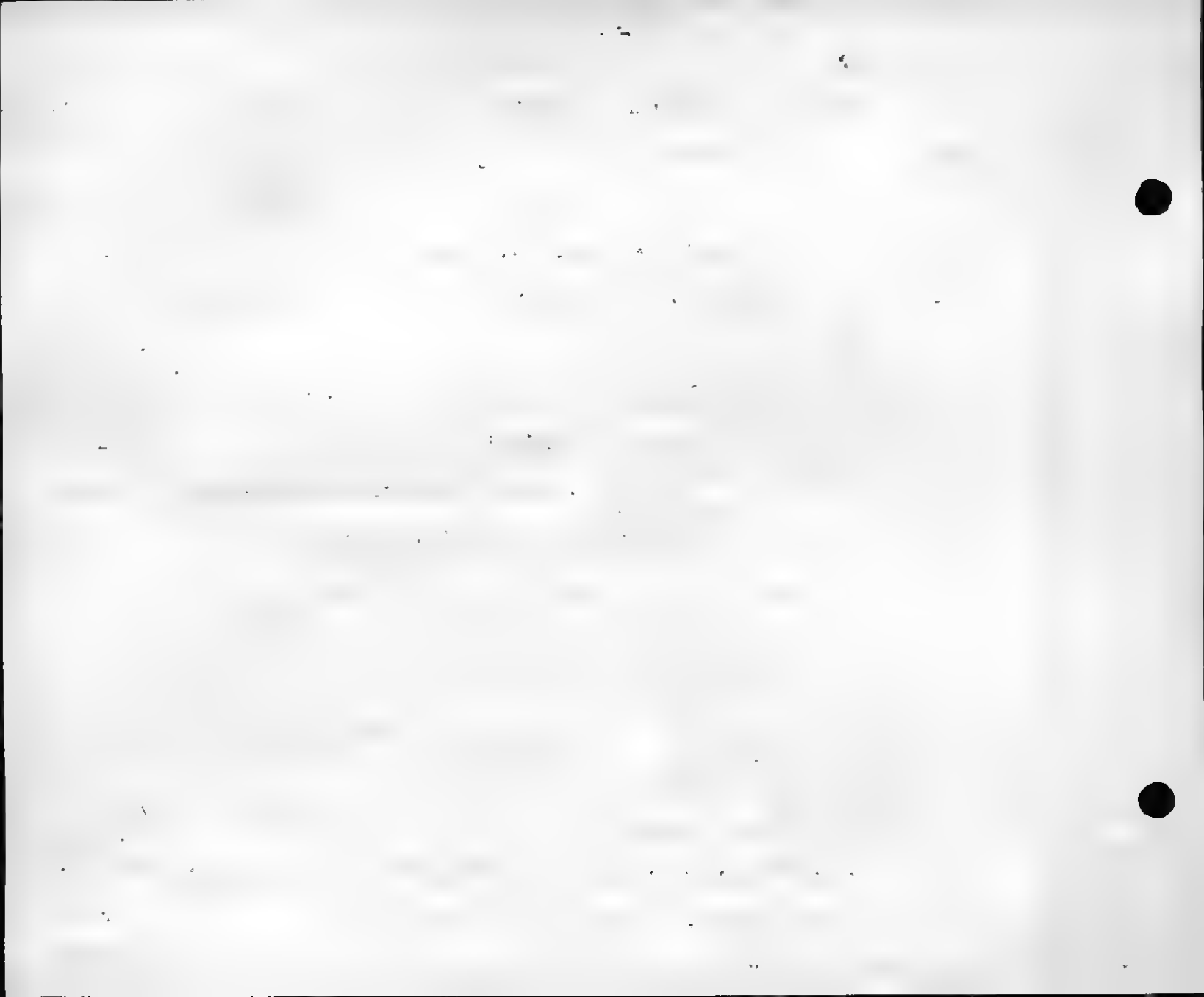


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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>NETTIE BLONDELL HATTON</b>			2a. DATE OF DEATH <b>April 5 Day 1968</b>		2b. HOUR <b>5:45 A.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>August 12, 1886</b>		6. AGE (In years last birthday) <b>81 YRS</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>WICOMICO</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>House work</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN <b>Mardela</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>Bridge Street</b>
14. FATHER'S NAME First Middle Last <b>John Elliott</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>-- Seabreeze</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>212-14-4717</b>	17. INFORMANT (Daughter) Address P.O. Box 127 <b>Mrs. George Dennis, Mardela Springs, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral thrombosis with dysarthria</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4100</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>April 2</b> , 19 <b>68</b> , to <b>April 5</b> , 19 <b>68</b> , that (X) (we) last saw the deceased alive on <b>April 5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>L. V. Maldve</b>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/5/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22e. ADDRESS <b>Deer's Head State Hospital, Salisbury, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>April 8, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mardela Memorial Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Mardela, Wicomico, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>APR 9 - 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last <b>LEVIN Gordy HAYMAN</b>			2a. DATE OF DEATH Month Day Year <b>APRIL 11 1968</b>			2b. HOUR MIN <b>5:20</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MAY 7 1908</b>		6. AGE (In years lost birthday) <b>59</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>PRODUCE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BUYER</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>WICO</b>		13c. CITY OR TOWN <b>SALISBURY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>921 N. PARK DR.</b>		14. FATHER'S NAME First Middle Last <b>CHARLES R. HAYMAN</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>MAY POLLITT</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-36-8182</b>		17. INFORMANT Address <b>MRS. L. B. HAYMAN - SEE #13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure.</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>A.S.C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Malnutrition of undiagnosed cause.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-20</b> , 1968, to <b>4-11</b> , 1968, that (I) (we) last saw the deceased alive on <b>4-11</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Joseph C. Fitzgerald</b>		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4-11-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>JOSEPH C. FITZGERALD</b>		22e. ADDRESS <b>MEDICAL CTR. SALISBURY, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>4/15/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARSONS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>SALISBURY WICO MD</b>	
24. FUNERAL DIRECTOR <b>George C. Hefner</b>		ADDRESS <b>Salisbury, MD.</b>		25a. REC'D BY REGISTRAR <b>APR 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





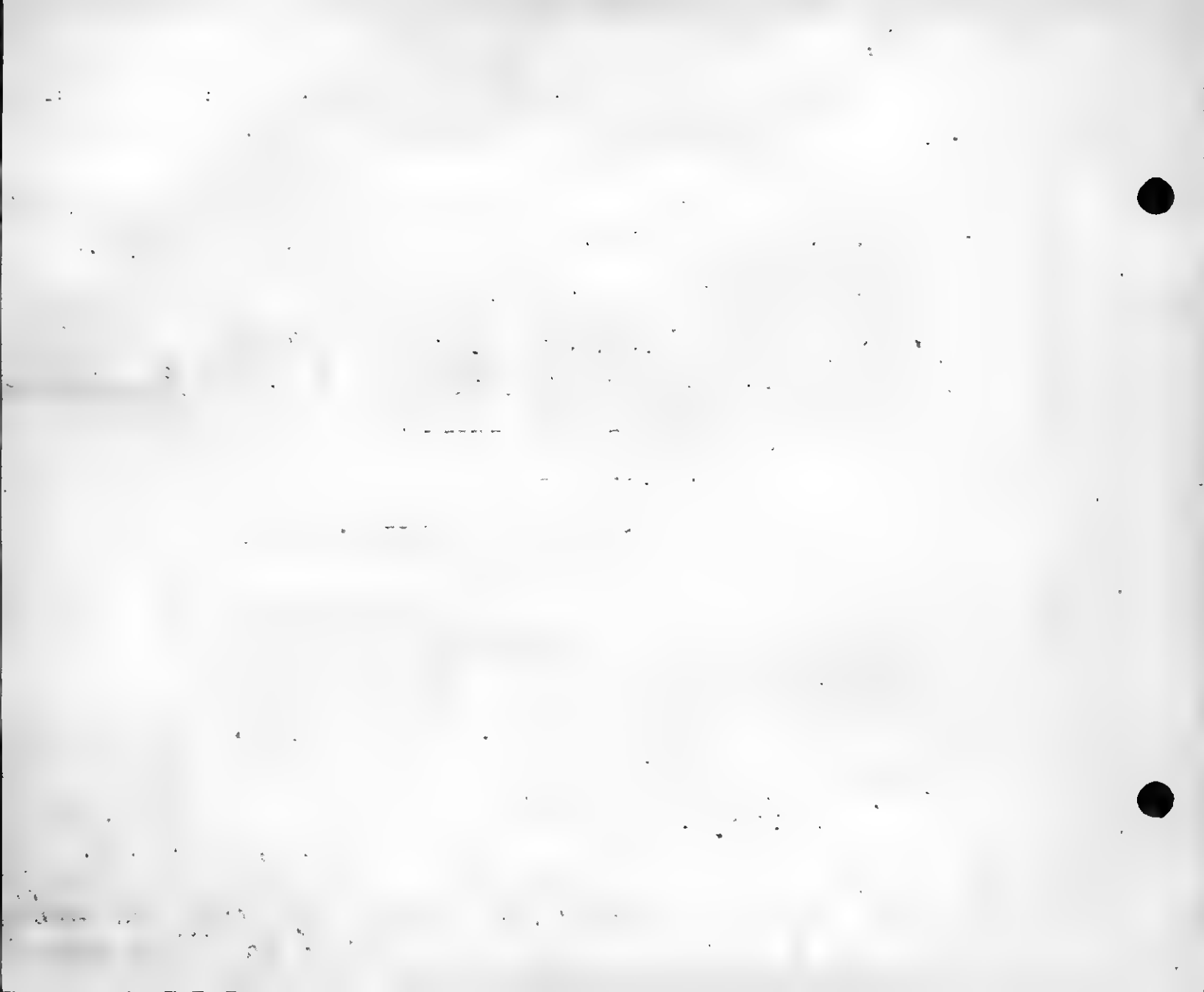
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MD634  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>CHARLES</b> <sup>First</sup> <b>JENKINS</b> <sup>Lost</sup>		2a. DATE OF DEATH <b>April</b> Month <b>12</b> Day <b>68</b> Year		2b. HOUR <b>8:20</b> PM	
3. SEX <b>Male</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>11/2/89</b>	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (In years lost <b>78</b> today) YRS. MONTHS DAYS HOURS M N	
7c. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>SALISBURY, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DEERSHEAD STATE</b>		9. COUNTY OF DEATH <b>WICOMICO</b> Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>TALBOT</b>		13c. CITY OR TOWN <b>Royal Oak</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>5607</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>milks</b>	
14. FATHER'S NAME First Middle Lost <b>Perry</b> <b>Jenkins</b>		15. MOTHER'S MAIDEN NAME First Middle Lost <b>Eller</b> <b>Fields</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. <b>220-09-5715</b>		17. INFORMANT <b>Sarah Lane</b>		Address <b>Royal Oak Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO-PNEUMONIA</b> -----Days <b>5900</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <b>UREMIA</b> -----Months DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC PYELONEPHRITIS</b> -----Yrs.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>6000</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 26</b> , 19 <b>68</b> , to <b>April 12</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>April 12 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A. C. Mitchell MD</b>				22c. DATE SIGNED <b>April 13, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Deershead Hospital, Salisbury, Md.</b>				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Apr. 16-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Royal Oak Cerm.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Royal Oak Talbot Md</b>		23e. REC'D BY REGISTRAR <b>Charles Judge</b>			
24. FUNERAL DIRECTOR <b>George N. Parkwell</b>		24b. ADDRESS <b>Easton Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

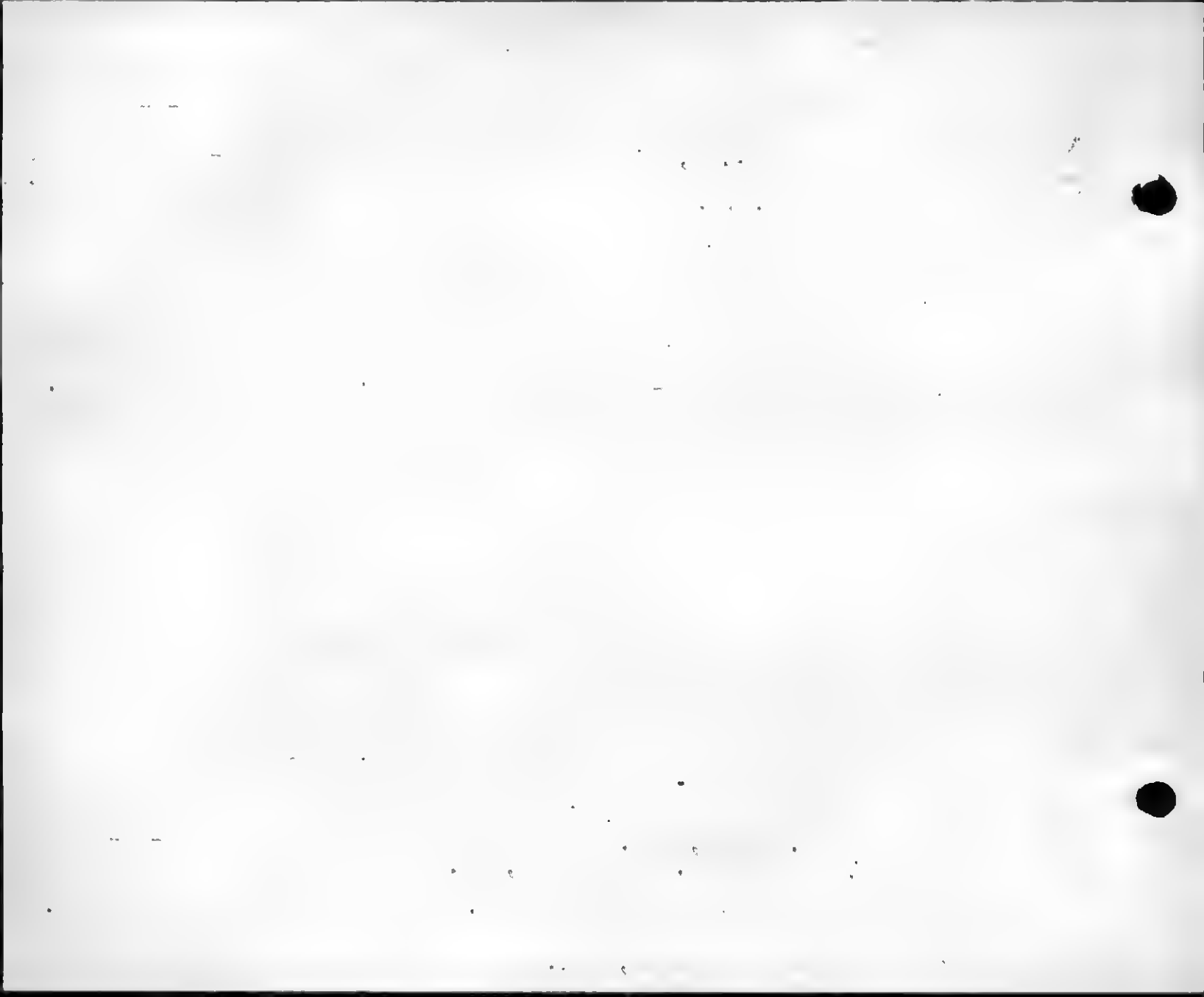


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-103-1. This may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

3035  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year 4-7-68 19 4:15 P.M.		2b HOJR
Essie Jane Johnson							
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year 4-7-68 4:15 P.M.
F	C	Oct. 5, 1908		59 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.	
Maryland		U.S.A.					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		2b KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER	
Delaware		Sussex		Selbyville			
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last
George Johnson					Hettie Brittingham		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS	
no		212-12-3711		Ella Mae Camper		Selbyville, Dela.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 420.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED		ADDRESS (Street, city, town, or county)	
		Earl L. Royer, M.D. 409 Camden Ave. Salisbury, Md.		4-10-68			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		4/13/68		Evergreen Cem.		Berlin, Worcester, Md	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Richard T. Watson Funeral Home Selbyville, Del.				APR 15 1968			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
30M REV 1/68

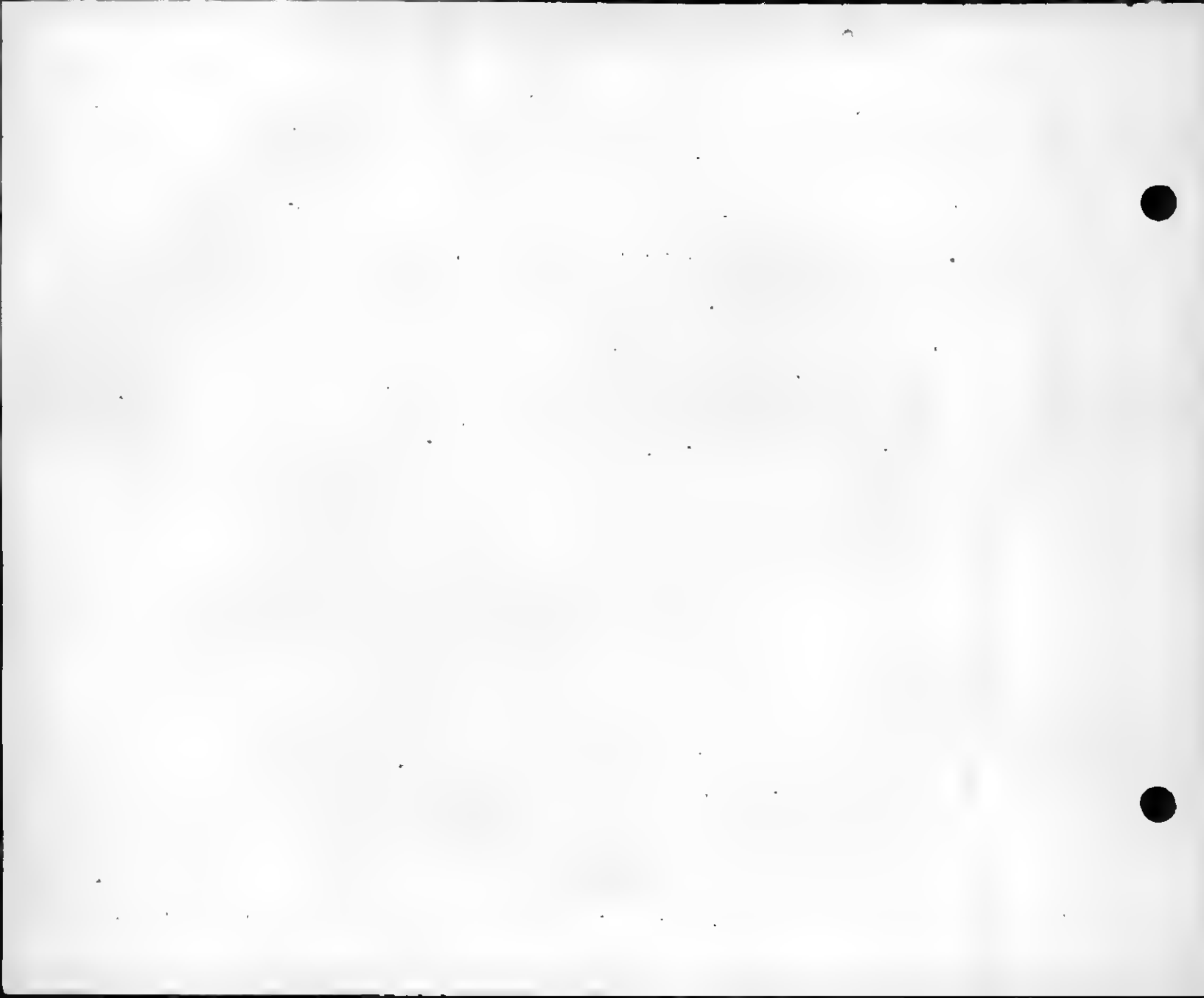
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1634

1. DECEASED-NAME (Type or print) <b>Franklin</b>		First		Middle		Last		2a. DATE OF DEATH Month <b>April</b> Day <b>18</b> Year <b>1968</b>		2b. HOUR <b>9:20</b> A M	
3 SEX <b>Male</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH <b>Dec. 25, 1903</b>				6 AGE (In years last birthday) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Laborer</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Delaware</b>		13b. COUNTY <b>Sussex</b>		13c. CITY OR TOWN <b>Millsboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Millsboro, Del.</b>			
14. FATHER'S NAME First <b>Edward</b> Middle <b>Joyner</b> Last <b>Joyner</b>		15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Smith</b> Last <b>Joyner</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO (If yes give war or dates of service) <b>224-09-6371</b>		17. INFORMANT <b>Lula Joyner</b>				Address <b>Millsboro</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Inter cerebral Heart Disease</b> <b>412.9</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>41</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 1963, to <b>April 18</b> , 1968, that (I) (we) last saw the deceased alive on <b>April 18</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.											
22b. SIGNATURE <b>David L. Milne</b>										22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>David L. Milne</b>										22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>April 22, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d. LOCATION (City or Town) <b>Millsboro, Del.</b>					
24. FUNERAL DIRECTOR <b>A. Douglas Meloy</b>		ADDRESS <b>Frankford, Del.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

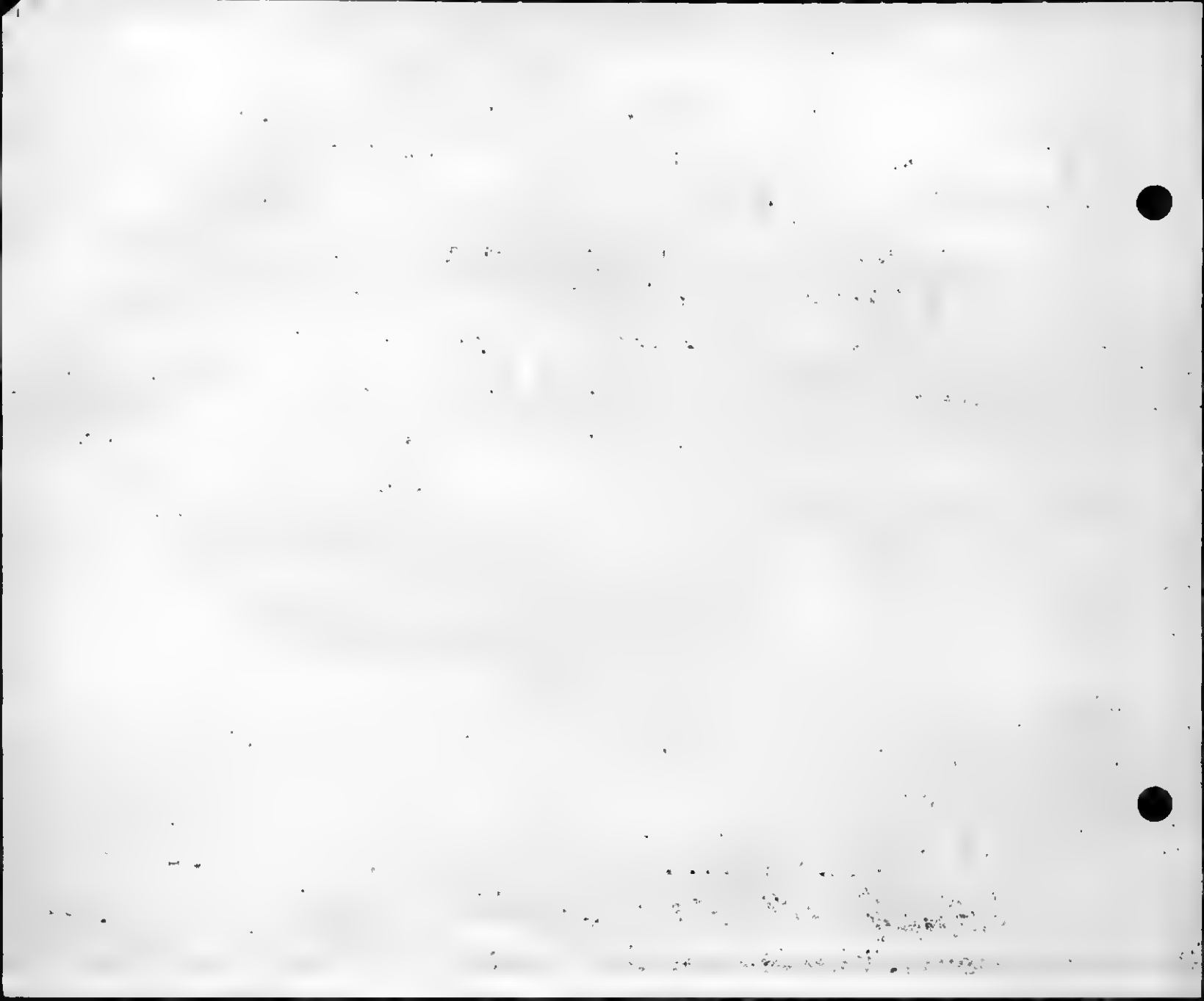
MEDICAL CERTIFICATION



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="display: flex; justify-content: space-between;"> <span>337</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>343</span> </div> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>											
1. DECEASED-NAME (Type or print) <div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> <p style="margin: 0;">Lucy G. Keesey</p>				2a. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> <span>Month</span> <span>Day</span> <span>Year</span> </div> <p style="margin: 0;">April 20 1968</p>				2b. HOUR 1 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH FEB. 29, 1887		6. AGE (in years last birthday) 81 YRS		7. UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (State or foreign country) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN NEAVITT		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME <div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> <p style="margin: 0;">CHARLES- A- GENTZLER</p>				15. MOTHER'S MAIDEN NAME <div style="display: flex; justify-content: space-between;"> <span>First</span> <span>Middle</span> <span>Last</span> </div> <p style="margin: 0;">ANNA EYSTER</p>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/>		16b. SOCIAL SECURITY NO 577-07-66438		17. INFORMANT DANIEL E-KEESEY		Address NEAVITT MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4437											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 9/25/67, 19, to 4/20/68, 19, that (I) (we) lost saw the deceased alive on 4/20/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE V. Maldre, M.D.				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/20/68			
22d. PHYSICIAN'S NAME (Type) I. Maldre, M.D.				22e. ADDRESS Box 2018, Salisbury, Md. - 21801							
23a. BURIAL, CREMAT., OR OTHER DISPOSITION Burial		23b. DATE APR. 23, 1968		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT		23d. LOCATION (City or Town) YORK		(County) PENNA.		(State)	
24. FUNERAL DIRECTOR Maurice A. Newcomer				ADDRESS Grafton, Md.		25a. REC'D BY REGISTRAR DATE APR 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year				2b. HOUR
HENRY PURNELL KELLY						OF DEATH ESTI- MATED <input type="checkbox"/> 4/3 1968				M
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c. DATE PRONOUNCED DEAD Month April Day 3 Year 1968		2d. HOUR
Male	White	July 24, 1881	86 YRS							M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md.				
Maryland		USA								
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Saw Mill operator			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Powellville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER R.D. 1, Pittsville
14. FATHER'S NAME John E. Kelly			15. MOTHER'S MAIDEN NAME Kate Lewis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service) 221-05-0475			17. INFORMANT (Son) ADDRESS Mr. C. Milton Kelly, Powellville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial degeneration 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio-vascular disease years Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7 Sub-trochanteric fracture of right hip.										
19a. DATE OF OPERATION 4-2-68			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture of right hip				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOJ.R.A.M. P.M. 3-29-68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell at nursing home.				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) nursing home		21f. LOCATION Street or R.F.D. No City or Town County State Berlin Nursing Home, Berlin, Worcester, Md.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.			22b. DATE SIGNED April 4 / 1968			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 6, 1968		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery			23d. LOCATION (City or Town) (County) (State) Powellville, Wicomico, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. RECD BY REGISTRAR APR 8 - 1968 DATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (2)  
304A REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <u>First</u> <u>Middle</u> <u>Last</u> <u>Maria</u> <u>Wm</u> <u>Lewis</u>			2a. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1968</u>			2b. HOUR <u>8 PM</u>	
3. SEX <u>Female</u>		4. RACE <u>Colored</u>		5. DATE OF BIRTH <u>March 1, 1914</u>		6. AGE (In years last birthday) <u>54</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>Salisbury, MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Wicomico</u> Md.	
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Peninsula General Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>		13b. COUNTY <u>Wicomico</u>		13c. CITY OR TOWN <u>Salisbury</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <u>Wm. H. H.</u> Middle <u>H.</u> Last <u>HOOPER</u>		15. MOTHER'S MAIDEN NAME First <u>Ruth</u> Middle <u>B.</u> Last <u>ROBERTS</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT <u>Kathleen Puckett</u> Address <u>495 Lake Street Salisbury, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> <u>10-18</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>RADIATION NECROSIS OF AMALGAM</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CA OF CERVIX</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>1714</u>							
19a. DATE OF OPERATION <u>7/21/68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PELVIC ABSCESS</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <u>19</u> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/15/68</u> , 19 <u>68</u> , to <u>4/14/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4/14/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Martin E. Zipser M.D.</u> DEGREE				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>4/16/68</u>	
22d. PHYSICIAN'S NAME (Type) <u>Martin E. Zipser, M.D.</u>				22e. ADDRESS <u>Peninsula General Hospital Salisbury, Maryland 21801</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>4-18-68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>James H. Jones</u> ADDRESS <u>Salisbury, MD</u>				25a. REC'D BY REGISTRAR DATE <u>APR 22 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD 340  
MAY 11 1968  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Homer LEVIN Littleton			2a. DATE OF DEATH Month Day Year April 8 1968		2b. HOUR 8:50 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 7, 1906		6. AGE (in years last birthday) 61 YRS.	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Wicomico Md.		
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) News Carrier	12b. KIND OF BUSINESS OR INDUSTRY Newspaper	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 607 Jackson Street	
14. FATHER'S NAME First Middle Last John B. Littleton		15. MOTHER'S MAIDEN NAME First Middle Last Annie Dixon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 220-32-9799		17. INFORMANT (Wife) Mrs. Elsie M. Littleton, Salisbury, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic heart disease 4125 DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 4-6, 1968, to 4-8, 1968, that (I) (we) last saw the deceased alive on 4-6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John S. Bulkeley, M.D.				22c. DATE SIGNED April 8, 1968	
22d. PHYSICIAN'S NAME (Type) Dr. John T. Bulkeley				22e. ADDRESS S. Salisbury Blvd., Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland		25a. REC'D BY REGISTRAR DATE APR 11 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge			

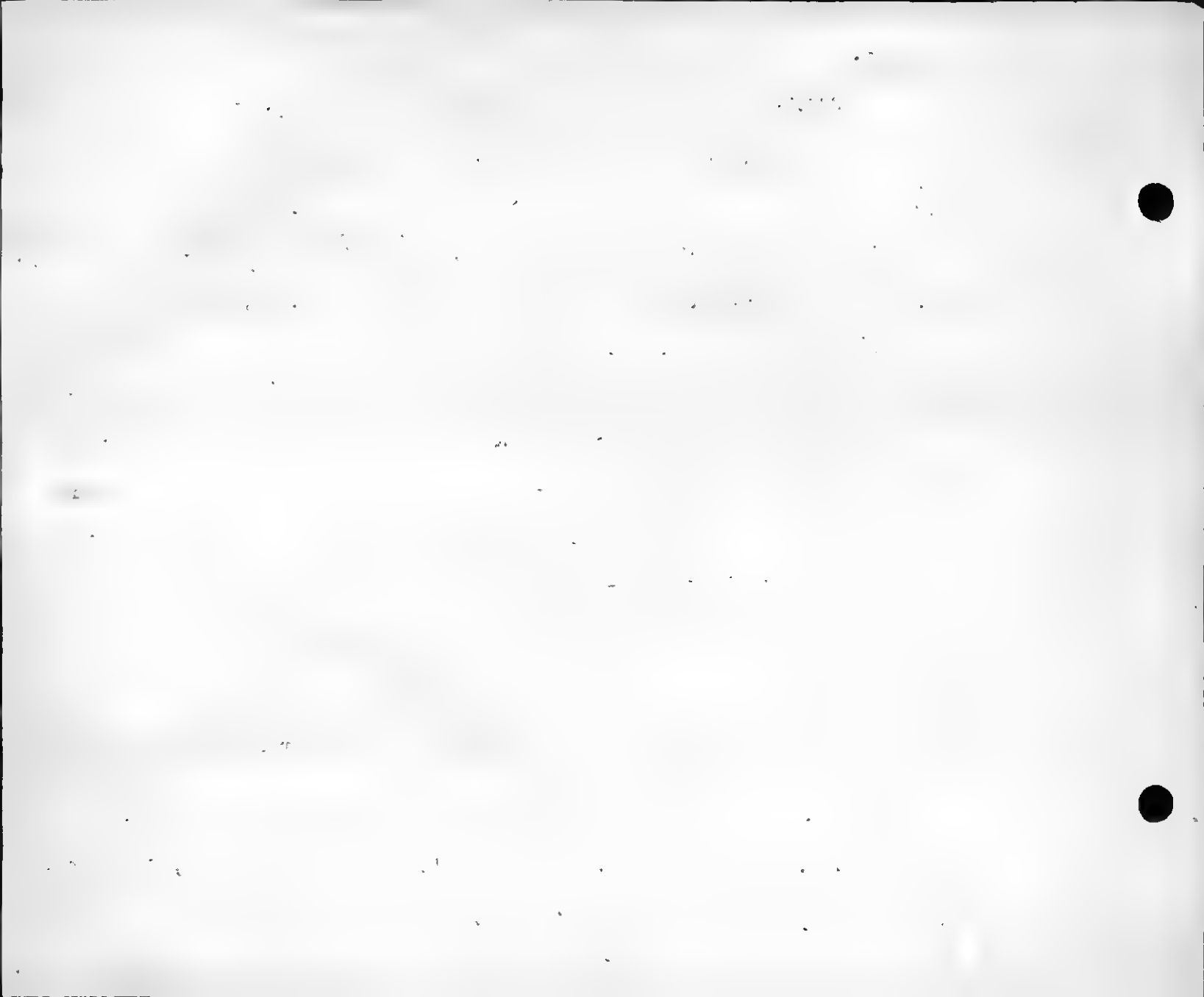


## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>EDWARD</b>		First Middle Last		2a. DATE OF DEATH Month Day Year <b>April 3 1968</b>		2b. HOUR <b>4:35 A M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Oct 12, 1877</b>		6. AGE (In years last birthday) <b>90</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WICOMICO</b> Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Crossing Watchman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Eden</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Edward Lyons Sr.</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Lillian Mueller</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO <b>717-05-4310</b>		17. INFORMANT <b>Harold Lyons RDI</b> Address <b>Eden Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>440.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>24 hours</b> <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Bilateral inguinal herniae - irreducible</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 12, 1968</b> , to <b>April 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>C. H. Winnacott</b>				22c. DATE SIGNED <b>4/3/68</b>		22d. PHYSICIAN'S NAME (Type) <b>C. H. Winnacott, M. D.</b>	
22e. ADDRESS <b>Deer's Head State Hospital, Salisbury,</b>		22f. ADDRESS <b>Deer's Head State Hospital, Salisbury,</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>4/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Deer's Head State Hospital</b>		23d. LOCATION (City or town) (County) (State) <b>Salisbury Wicomico N. York</b>	
24. FUNERAL DIRECTOR <b>William M. Wood</b>		25a. REC'D BY REGISTRAR <b>APR 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John E. Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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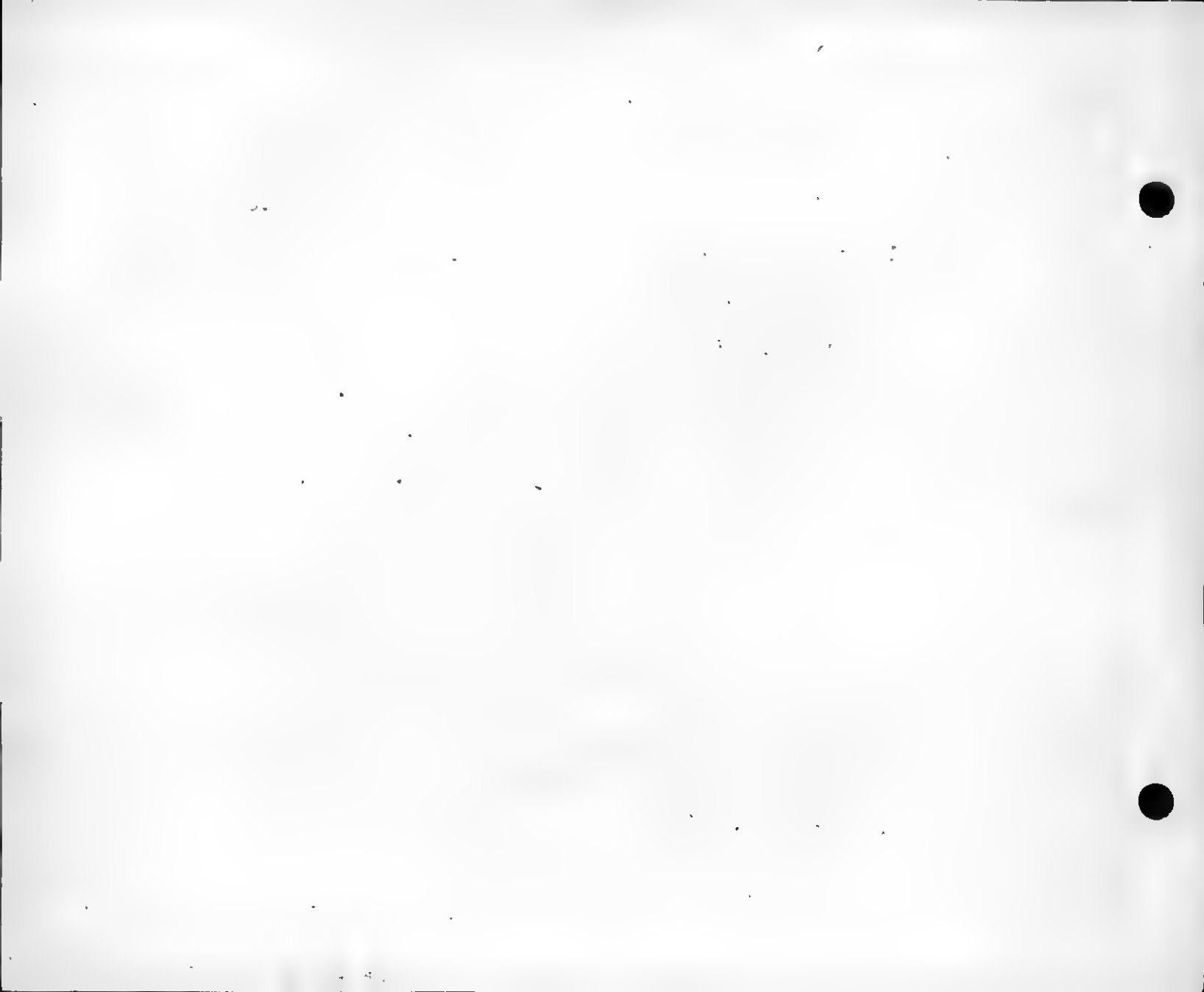
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VR A15-1  
304A REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>FRANCIS W. MASSEY</b>			2a. DATE OF DEATH Month <b>Apr</b> Day <b>1</b> Year <b>68</b>			2b. HOUR <b>8:50 PM</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>JAN 11, 1909</b>		6. AGE (In years last birthday) <b>59</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>OCEAN CITY MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>ELECTRICAL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONTRACTOR</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>OCEAN CITY MD</b>		13b. COUNTY <b>Wor</b>		13c. CITY OR TOWN <b>OCEAN CITY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>MARLIN DRIVE</b>		14. FATHER'S NAME First <b>George W</b> Middle <b>MASSEY</b> Last <b>MASSEY</b>		15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>JONES</b> Last <b>JONES</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>YES World War II</b>		16b. SOCIAL SECURITY NO. <b>441.2</b>		17. INFORMANT <b>Mrs. F.W. Massey</b>		Address <b>OCEAN CITY MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured abdominal</b> <b>441.2</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>arterio sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>441.2</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/17</b> , 19 <b>68</b> , to <b>4/19</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/19</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Richard P. Hughes</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4/19/68</b>			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
23a. BURIAL CREMATION. REMOVAL (Specify)		23b. DATE <b>4/22/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		23d. LOCATION (City or Town) (County) (State) <b>BERLIN WOR. MD</b>	
24. FUNERAL DIRECTOR <b>Anna A. Burbage</b>		ADDRESS <b>Berlin Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Young</b>	



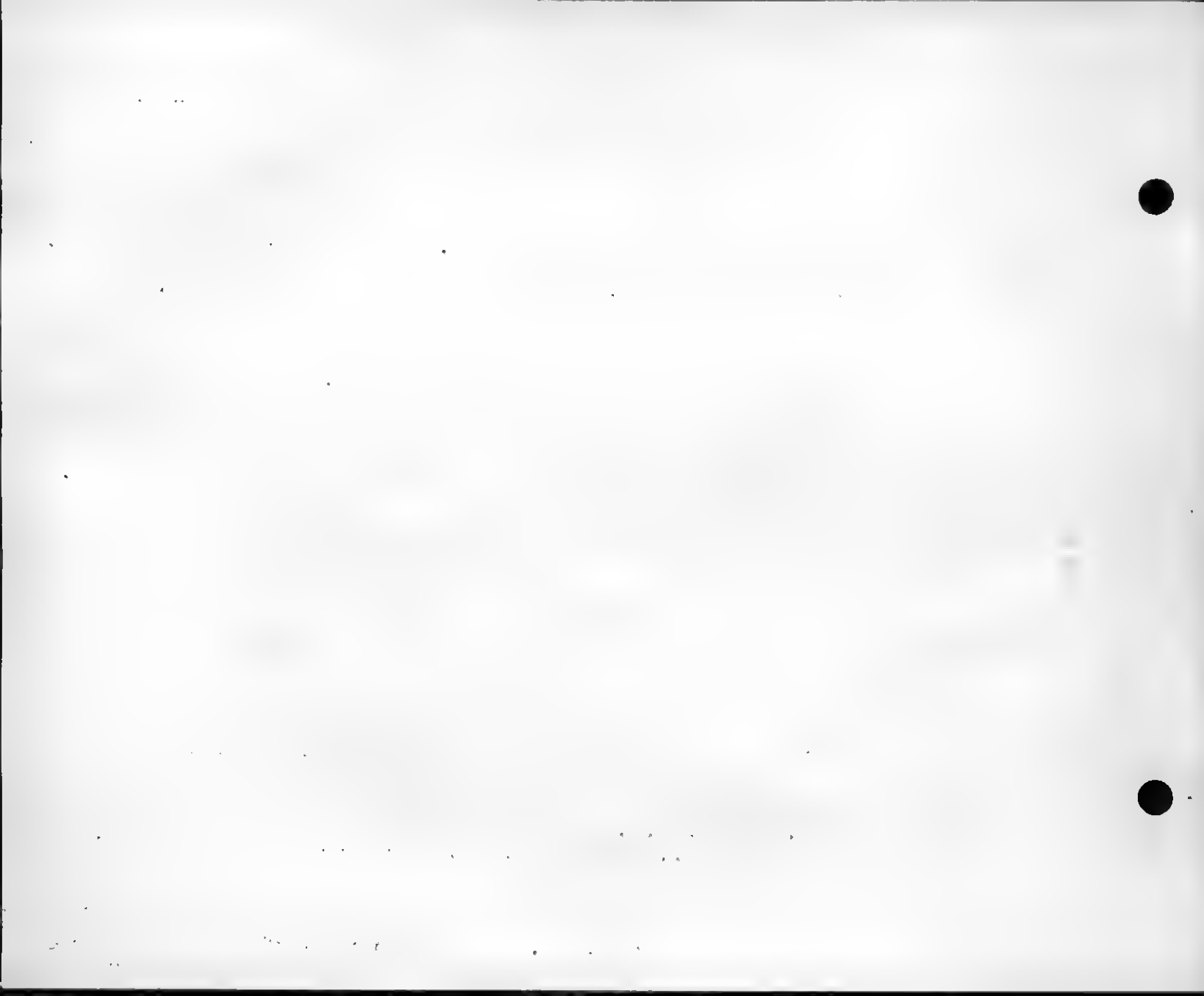
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD 43  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH	<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR OF DEATH
ROBERT LEE McBRIDE					4-19-68				6:30 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)	7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD
M	W	Oct 21, 1907		60 YRS	MONTHS DAYS		HOURS MIN		Month 4 Day 19 Year 1968
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Va.		US		Wicomico				Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Delmar		100 Pine St.		Painter		Paint			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		Wicomico		Delmar		YES <input type="checkbox"/> NO <input type="checkbox"/>		100 Pine St.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Bruce James		Kate Garrett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS			
		228-05-5261		Eddie J. McBride		Delmar Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion									sudden
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION									20. AUTOPSY?
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
		HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
Earl L. Royer, M.D.								April 20, 1968	
EXAMINER'S NAME (Type)		ADDRESS		23a. REC'D BY REGISTRAR					
409 Camden Ave., Salisbury, Md.				DATE Apr 22 1968					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		25b. REGISTRAR'S SIGNATURE	
Buried		4/23/68		Bayboro Cem		Agnes Perry, J. Coe		James J. J. Coe	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR					
Marvel Funeral Home, Delmar, Md.				DATE Apr 22 1968					



Page 4 may be retained by the hospital or attending physician.

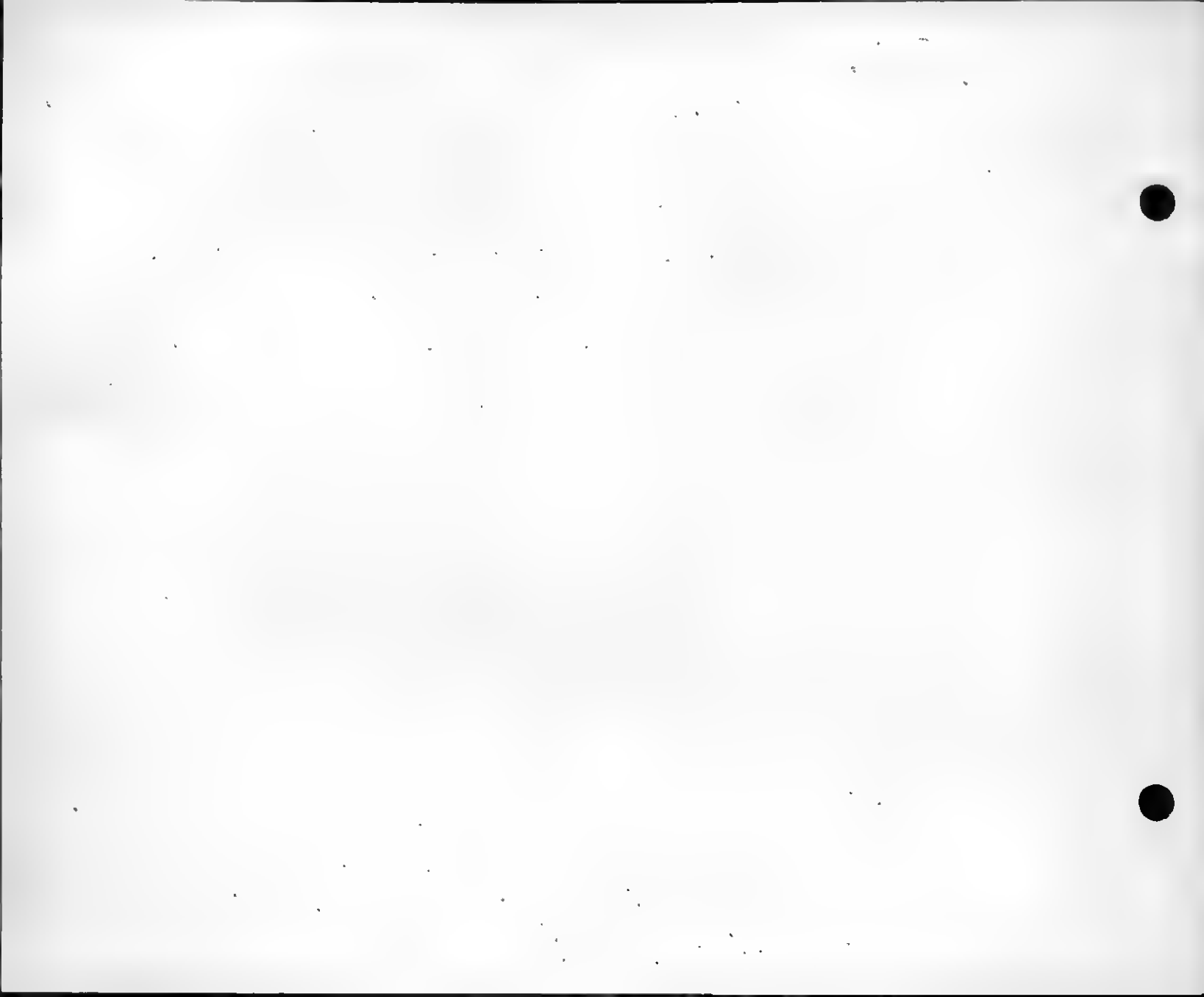
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

231

24 FUNERAL DIRECTOR



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

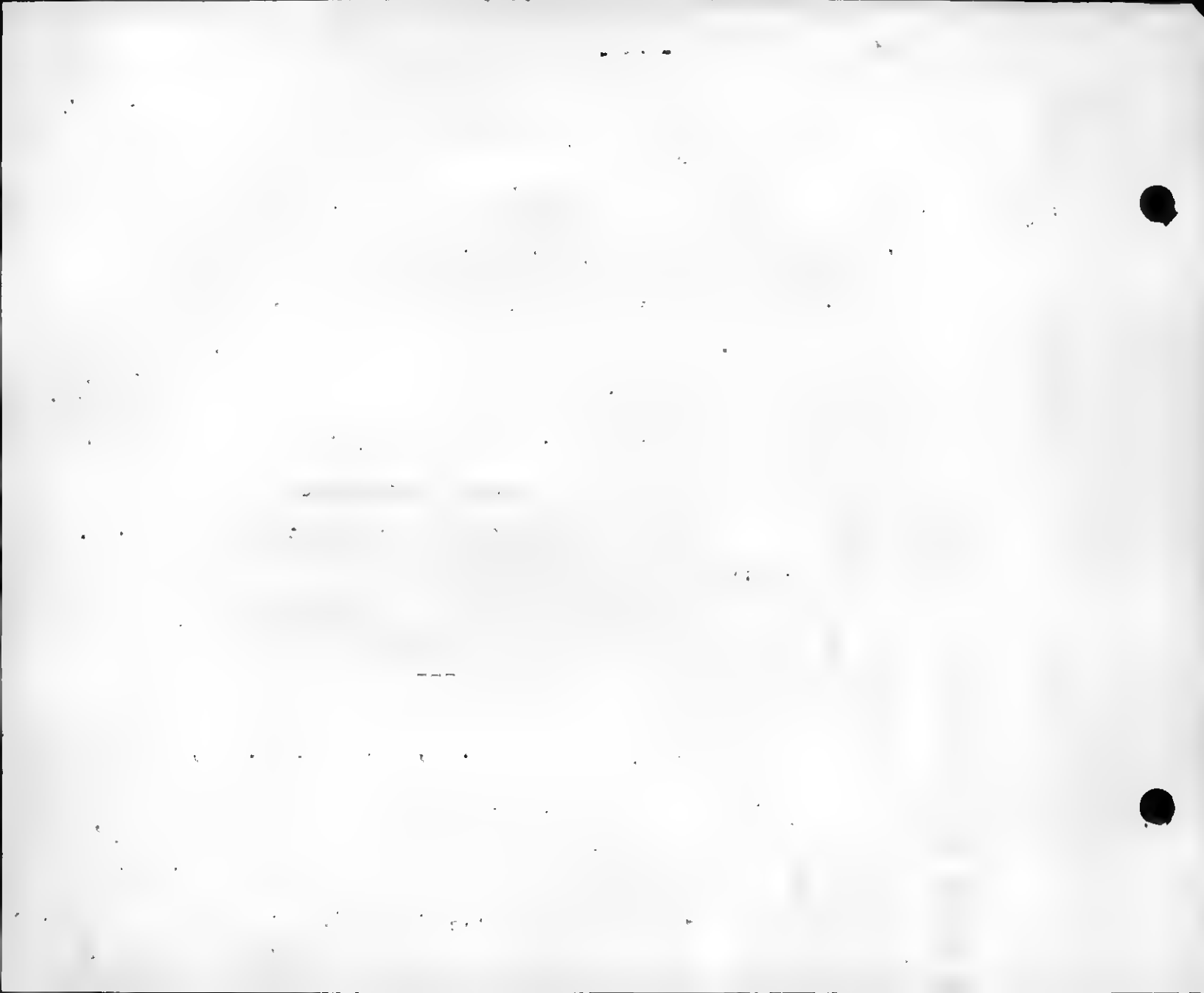
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, and 4 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MD 245  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last HARRY LEE MESSICK			2a. DATE OF DEATH Month Day Year April 14 1968			2b. HOUR 7:15AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 22, 1901		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md.	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Grocer		12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Tyaskin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER R.D.		14. FATHER'S NAME First Middle Last George H. Messick		15. MOTHER'S MAIDEN NAME First Middle Last Anna M. Wainwright			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 218-20-6508		17. INFORMANT (Son) Address Mr. Harry Lee Messick, Jr., 512 Hammond St., Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pulmonary Infarction 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease Hour ? 16 Das Unk.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 421 Obesity; Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) ----			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Mar 28, 1968, to Apr 14, 1968 that (I) (we) last saw the deceased alive on April 13, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Herbert Sembly M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 15, 1968	
22d. PHYSICIAN'S NAME (Type) DR. G. Herbert Sembly				22e. ADDRESS 400 E. Church St., Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 16, 1968		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DATE APR 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

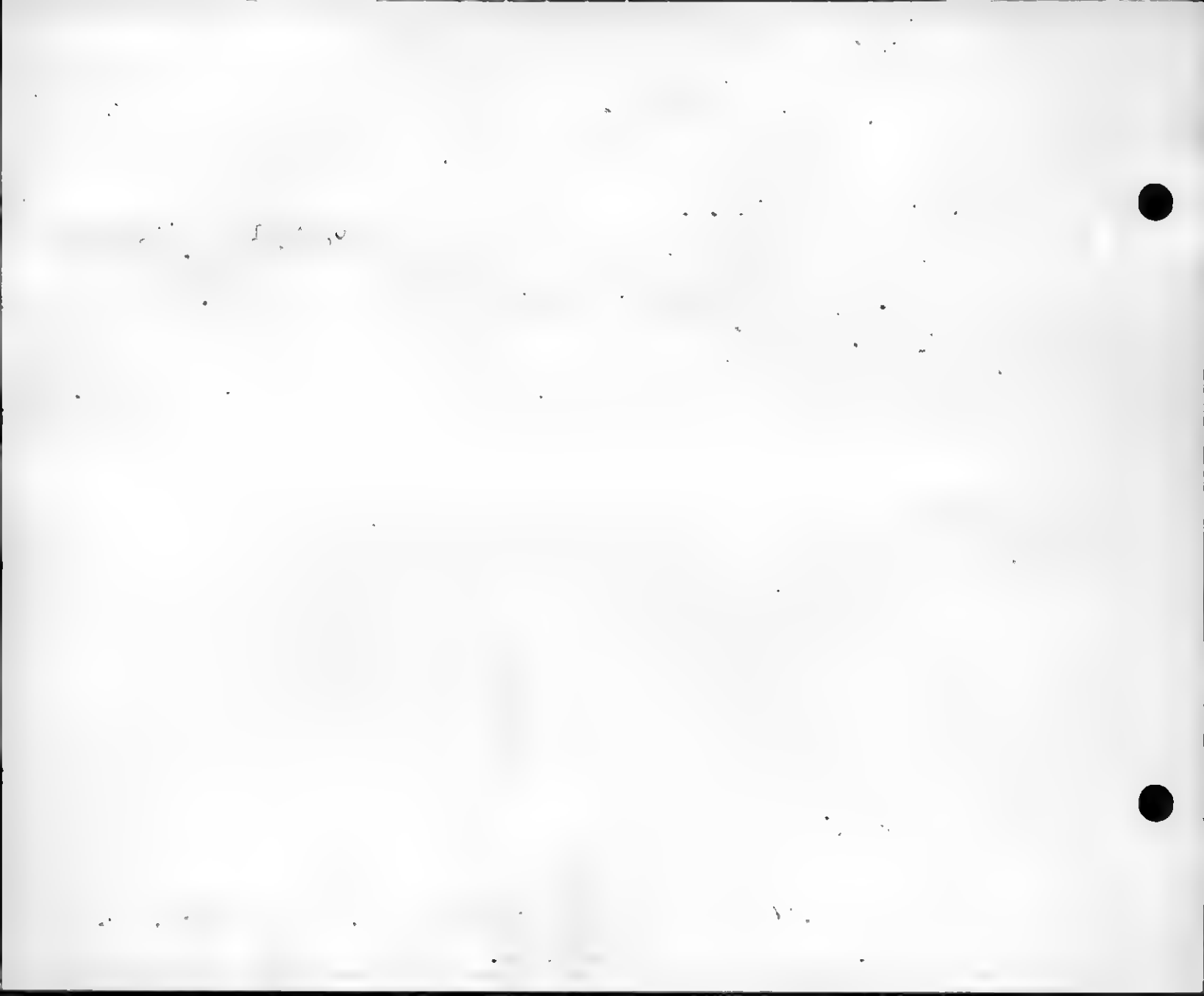
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MD348

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>Clarence Allen</i> First Middle Last		2a. DATE OF DEATH Month <i>APRIL</i> Day <i>3</i> Year <i>1968</i>		2b. HOUR <i>12:45</i> AM
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>OCT. 13, 1913</b>		6. AGE (In years last birthday) <b>54</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Wicomico</b> Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL PLACE OF WORK (If not in hospital give street address) <b>Board of Health</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>MD.</b>	13b. COUNTY <b>SOMERSET</b>	13c. CITY OR TOWN <b>PRINCESS ANNE</b>	13d. INS. DE CITY LIMITS? <b>YES</b> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>PINE ST.</b>
14. FATHER'S NAME First Middle Last <b>CLARENCE MILES</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>ADA BUTLER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>YES</b> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address <b>MRS ALLEN MILES PRINCESS ANNE, MD.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>From negative septicemia</i> <b>402x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Infectious &amp; Empyema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Postoperative pulmonary surgery</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>7/2/68</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Far advanced pulmonary emphysema</i>				
19a. DATE OF OPERATION <i>3/15/68</i>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Cept W lung</i>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Richard L. Hughes</i>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED <i>4/4/68</i>	
22d. PHYSICIAN'S NAME (Type) <b>Richard L. Hughes</b>		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>4/25/1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BEECHWOOD MEMORIAL CEM. PRINCESS ANNE, MD.</b>	23d. LOCATION (City or Town) (County) (State) <b>PRINCESS ANNE, MD.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>LEVIN R. WILSON PRINCESS ANNE, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 9 - 1968</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

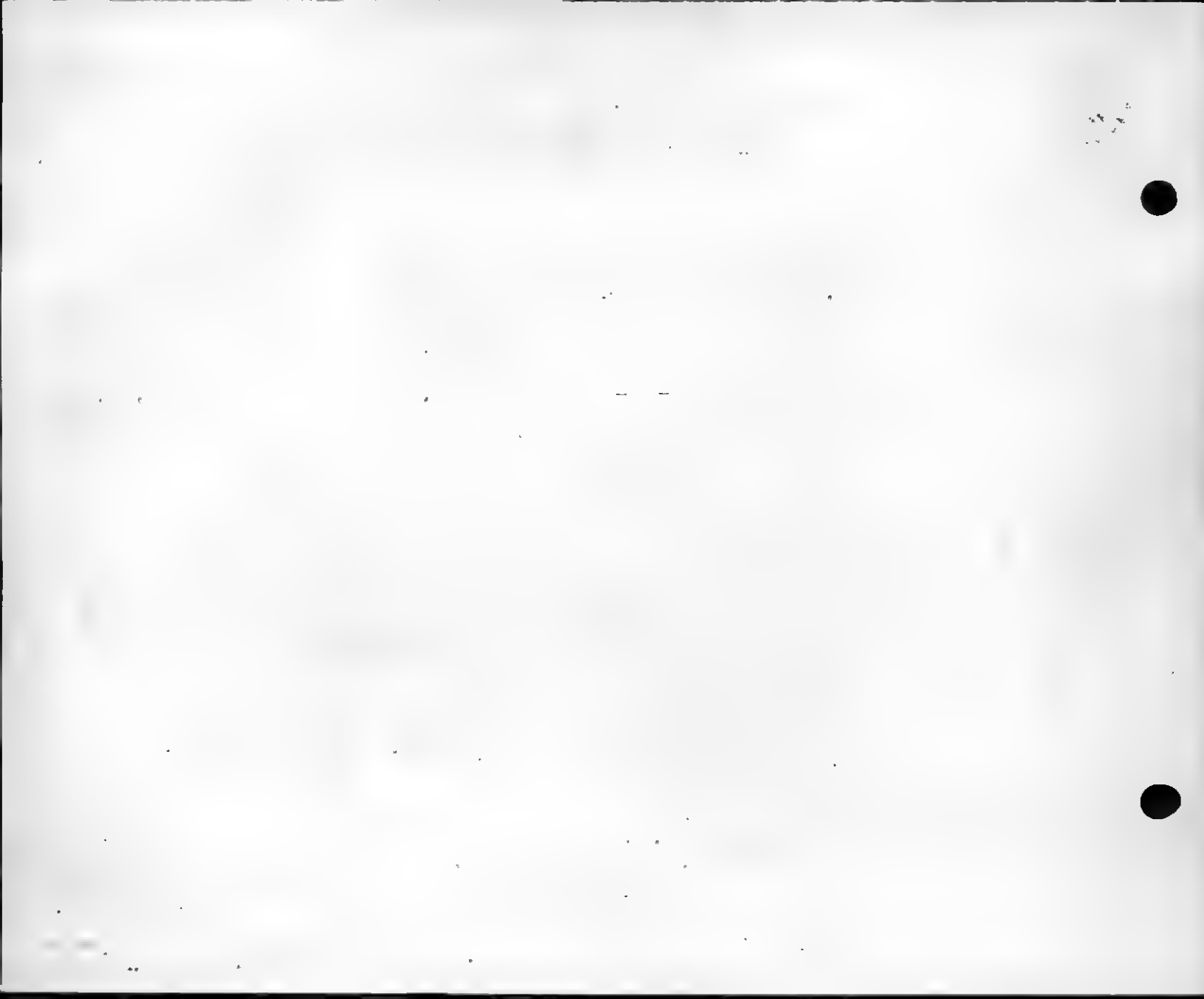


FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>347</div> <div>35</div> <div>3</div>											
<div>1 DECEASED NAME (Type or Print)</div> <div>First</div> <div>Middle</div> <div>Last</div>											
<div>Margaret B. Murray</div>											
<div>2a DATE KNOWN OF DEATH</div> <div>Month</div> <div>Day</div> <div>Year</div>		<div>2b HOUR</div> <div>54</div> <div>PM</div>									
<div>3 SEX</div> <div>F</div>		<div>4 RACE</div> <div>W</div>		<div>5 DATE OF BIRTH</div> <div>10-21-1888</div>		<div>6 AGE (In years not birthday)</div> <div>79 YRS</div>		<div>IF UNDER 1 YEAR</div> <div>MONTHS</div> <div>DAYS</div>		<div>IF UNDER 24 HRS</div> <div>HOURS</div> <div>MIN</div>	
<div>7a BIRTHPLACE (State or foreign country)</div> <div>Delaware</div>		<div>7b CITIZEN OF WHAT COUNTRY?</div> <div>Selbyville</div>		<div>8 MARRIED</div> <div>NEVER MARRIED</div> <div>WIDOWED</div> <div>DIVORCED</div>		<div>9 COUNTY OF DEATH</div> <div>Wicomico</div>					
<div>10 CITY OR TOWN OF DEATH</div> <div>Salisbury</div>				<div>11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>Peninsula General</div>				<div>12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)</div> <div>Housework</div>		<div>12b KIND OF BUSINESS OR INDUSTRY</div> <div>OWN home</div>	
<div>13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE</div> <div>Md.</div>				<div>13b COUNTY</div> <div>Worcester</div>		<div>13c CITY OR TOWN</div> <div>Whaleysville</div>		<div>13d INSIDE CITY LIMITS?</div> <div>NO</div>		<div>13e STREET AND NUMBER</div> <div>Route 1</div>	
<div>14 FATHER'S NAME</div> <div>First</div> <div>Middle</div> <div>Last</div>						<div>15 MOTHER'S MAIDEN NAME</div> <div>First</div> <div>Middle</div> <div>Last</div>					
<div>William Curtis Murray</div>						<div>Julia K. Campbell</div>					
<div>16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>XX</div>				<div>16b SOCIAL SECURITY NO</div> <div>XX</div>		<div>17 INFORMANT</div> <div>ADDRESS</div>					
<div>20</div>				<div>219-34-3688</div>		<div>Olive E. Murray</div> <div>Whaleysville, Md.</div>					
<div>18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div>											
<div>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</div> <div>4129</div> <div>Acute pulmonary edema</div> <div>minutes</div>											
<div>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE</div> <div>lost</div>											
<div>(b)</div> <div>Chronic congestive heart failure</div> <div>months</div>											
<div>(c)</div> <div>Arteriosclerotic cardio-vascular disease</div> <div>years</div>											
<div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)</div> <div>4221</div>											
<div>19a. DATE OF OPERATION</div>				<div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div>				<div>20 AUTOPSY?</div> <div>YES</div> <div>NO</div>			
<div>21a. EXTERNAL CAUSE WAS PRIMARY</div> <div>OR CONTRIBUTING</div> <div>CAUSE OF DEATH</div>				<div>21b. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>HOUR A.M.</div> <div>P.M.</div> <div>19</div>				<div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)</div>			
<div>21d. INJURY OCCURRED</div> <div>WHILE AT WORK</div> <div>NOT WHILE AT WORK</div>				<div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div>				<div>21f. LOCATION</div> <div>Street or R.F.D. No</div> <div>City or Town</div> <div>County</div> <div>State</div>			
<div>22a I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from:</div> <div>Natural causes</div> <div>Accident</div> <div>Suicide</div> <div>Homicide</div> <div>Undetermined manner</div>											
<div>ACTUAL SIGNATURE</div> <div>EXAMINER'S NAME (Type)</div>						<div>CHIEF MEDICAL EXAMINER</div> <div>ASSISTANT MEDICAL EXAMINER</div> <div>DEPUTY MEDICAL EXAMINER</div>					
<div>Earl L. Royce, M.D.</div> <div>409 Camden Ave., Salisbury, Md.</div>						<div>22b. DATE SIGNED</div> <div>April 29, 1968</div>					
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>				<div>23b. DATE</div> <div>5/1/68</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Red Man</div>		<div>23d. LOCATION (City or Town) (County) (State)</div> <div>Selbyville Sussex Del.</div>			
<div>24. FUNERAL DIRECTOR</div> <div>Whaley Funeral Home, Selbyville, Del.</div>						<div>25a. REC'D BY REGISTRAR</div> <div>DATE</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>			
<div>MAY 3 1968</div>											



# FOR STATE HEALTH DEPT.

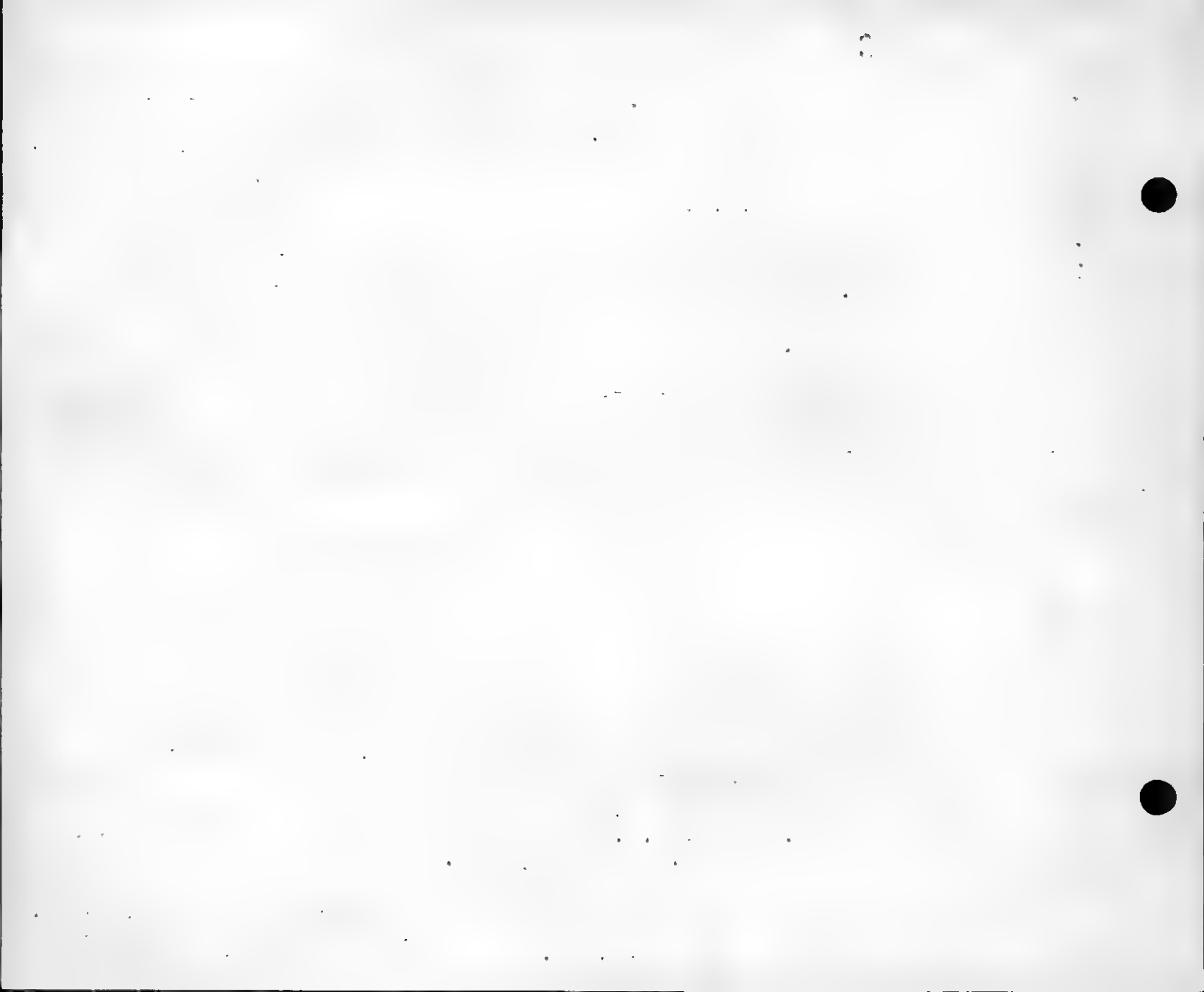
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## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <b>ADA</b>			First Middle Last <b>B. NELSON</b>			2a DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> <b>4-18-68</b> 19 <b>5:45</b> PM			2b HOUR		
3 SEX <b>F</b>	4 RACE <b>AA</b>	5 DATE OF BIRTH <b>3-23-97</b>	6 AGE (in years last birthday) <b>71</b> YRS	IF UNDER 1 YEAR MONTHS	DAYS	F UNDER 24 HRS HOURS	MIN	2c DATE PRONOUNCED DEAD Month <b>4</b> Day <b>18</b> Year <b>1968</b>			2d HOUR <b>5:45</b> PM
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Wicomico</b> Md.					
10 CITY OR TOWN OF DEATH <b>Hebron</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route 1</b>			12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Domestic</b>			12b KIND OF BUSINESS OR INDUSTRY		
13a USJA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Hebron</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>Route 1</b>		
14. FATHER'S NAME First Middle Last <b>John L. Horsey</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Epluribus Morris</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b SOCIAL SECURITY NO. <b>217-14-8317-A</b>			17. INFORMANT ADDRESS <b>Gladys Palmer Spring Hill Road</b>					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardio-vascular disease</b> years DUE TO, OR AS A CONSEQUENCE OF (c) <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>720.</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year <b>19</b> HOUR A.M. P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		County State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.			EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED <b>April 20, 1968</b>		
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>4/22/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>St. Mark</b>			23d LOCATION (City or Town) (County) (State) <b>Rockaway Wicomico Md.</b>			
24 FUNERAL DIRECTOR <b>Clinton Stewart</b> ADDRESS <b>Salisbury, Md.</b>						25a RECEIVED BY REGISTRAR DATE <b>APR 25 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

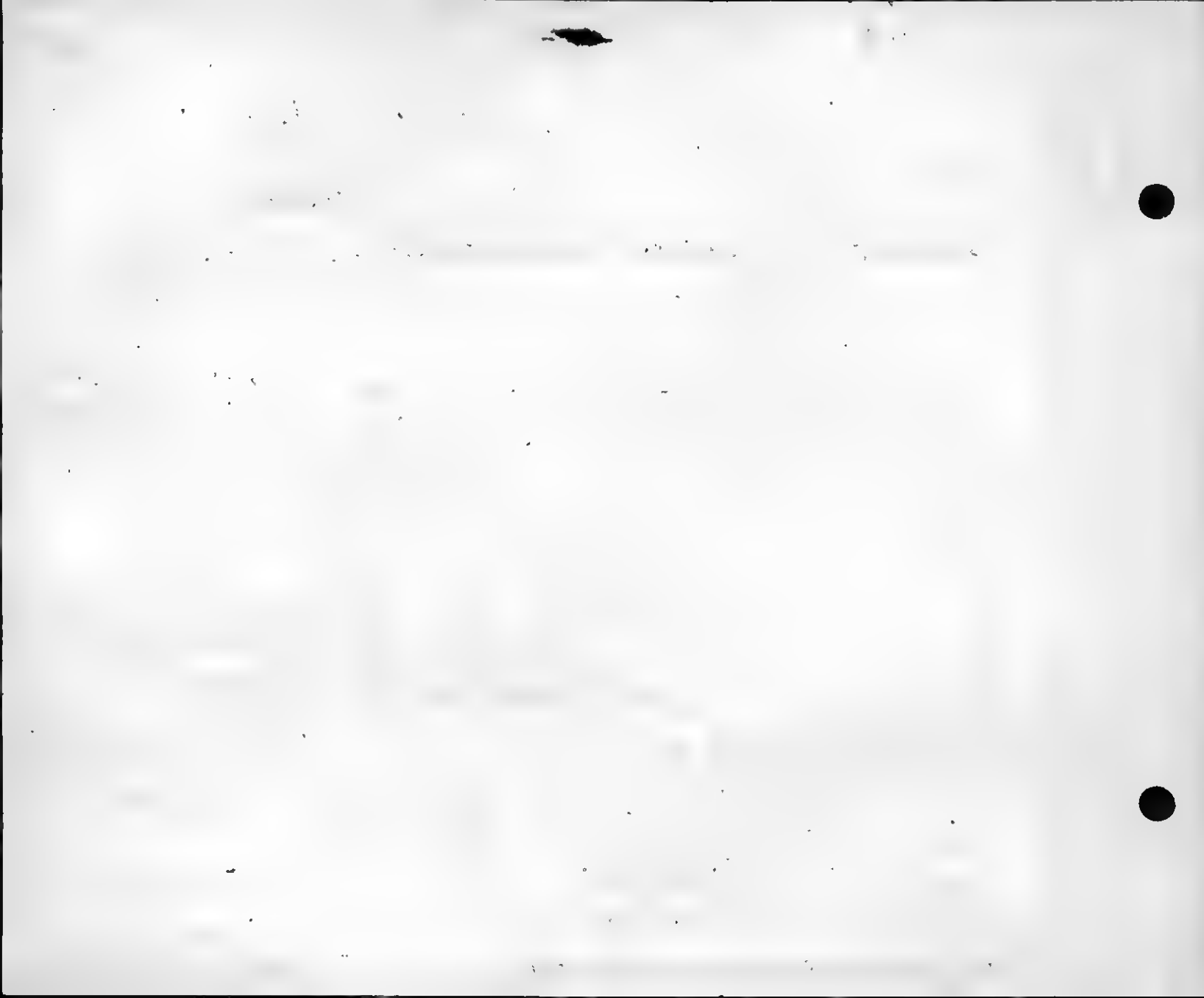
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304A REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS  
RESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>Edward -- Niemann</b>			2a. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>1968</b>			2b. HOUR <b>8 15</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 11, 1884</b>		6. AGE (In years lost birthday) <b>83</b> YRS.			
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>			12a. USUAL OCCUPATION (Kind of work done at most of working life, even if retired) <b>Retired Elect. Engineer</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Bernard -- Niemann</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Anna -- Boenau</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>214-10-7944</b>		17. INFORMANT (Wife) <b>Mrs. Mary Niemann, Salisbury, Maryland</b>			17a. ADDRESS <b>116 E. Isabella Street</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>4004</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , to <b>4-8</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-8</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Wilber R. Ellis, Jr.</b> DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED <b>4-8-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dr. Wilber R. Ellis, Jr.</b>		22e. ADDRESS <b>Medical Center, Salisbury, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 12, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bronx, N. Y.</b>			
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>APR 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION





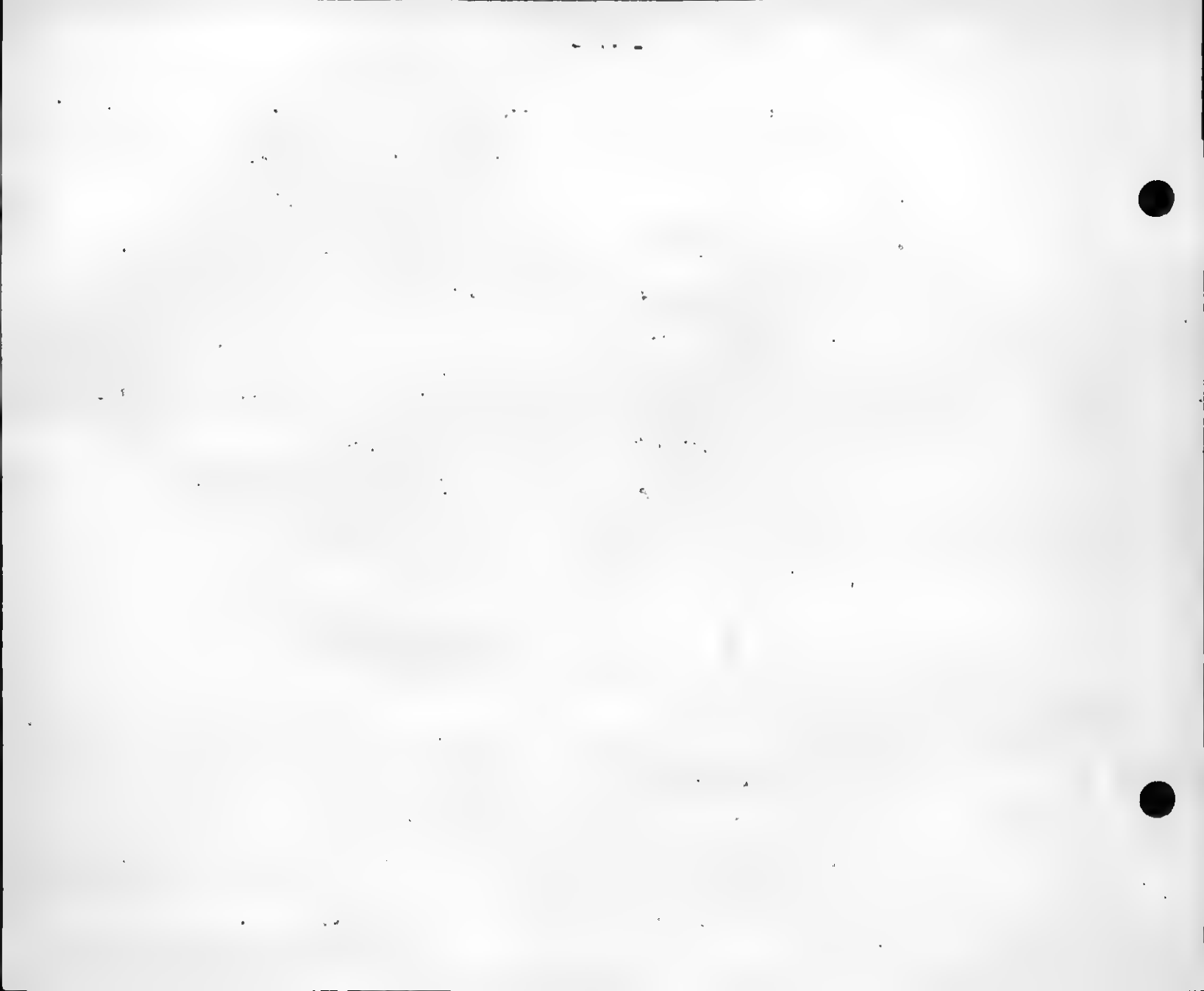
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>HARVEY</b>		First Middle Last <b>JAMES</b>		Last <b>PARKER, JR.</b>		2a. DATE OF DEATH Month Day Year <b>APRIL 15 1968</b>			2b. HOUR <b>1 A M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 4, 1897</b>		6. AGE (In years last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Brick Mason</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>208 Snow Hill Road</b>			
14. FATHER'S NAME First Middle Last <b>Harvey J. Parker, St.</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma F. Farlow</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>Yes</b>		(If yes give war or dates of service) <b>War I</b>		16b. SOCIAL SECURITY NO		17. INFORMANT (Wife) <b>208 Snow Hill Road</b> <b>Mrs. Mary A. Parker, Salisbury, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4211</b> (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Hiatus Hernia</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>October 1967</b> to <b>April 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>April 15, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Thomas C. Hill, Jr.</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>4-15-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Dr. Thomas C. Hill, Jr.</b>		22e. ADDRESS <b>Pine Bluff Road, Salisbury Md</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 18, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Wicomico, Maryland</b>					
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>APR 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



# FOR STATE HEALTH DEPT.

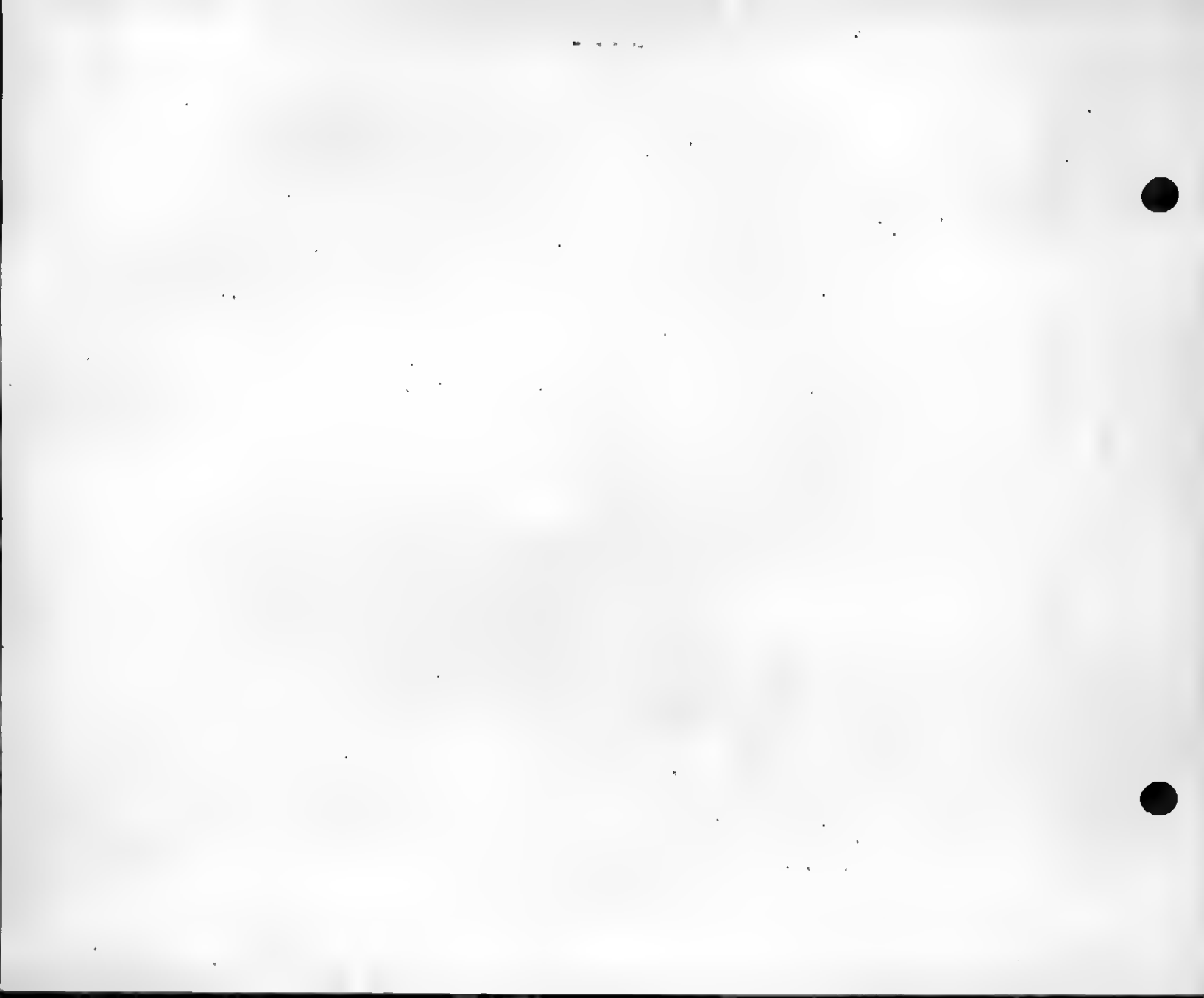
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <b>HORACE ROBERT PARKER</b>			2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> <b>4/14</b> 19 <b>68</b>			2b HOUR <b>M</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>August 15, 1921</b>	6 AGE (In years last birthday) <b>46</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c DATE PRONOUNCED DEAD Month <b>April</b> Day <b>14</b> Year <b>1968</b>		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <b>WICOMICO</b> Md.		
10 CITY OR TOWN OF DEATH <b>Salisbury</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>606 Liberty Street</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House Painter</b>		12b KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Wicomico</b>	13c CITY OR TOWN <b>Salisbury</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>606 Liberty Street</b>		
14 FATHER'S NAME First <b>James</b> Middle <b>Benjamin</b> Last <b>Parker</b>			15 MOTHER'S MAIDEN NAME First <b>Irma</b> Middle <b>Ellen</b> Last <b>Twilley</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16b SOCIAL SECURITY NO (If yes give war or dates of service) <b>War II</b>		17 INFORMANT (mother) <b>Mrs. Irma E. Parker, Salisbury, Maryland</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>481X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) <i>Lobar pneumonia</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4, X</b>								
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Philip A. Insley</i> EXAMINER'S NAME (Type) <b>Dr. Philip A. Insley</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED <b>April 14-15/1968</b>		
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>April 17, 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Odd Fellows Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Seaford Delaware</b>	
24 FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>					25a REC'D BY REGISTRAR <b>APR 17 1968</b>		25b REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MD 252  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

81  
6358

1. DECEASED-NAME (Type or print) <u>Nelson</u>			First Middle Last			2a. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1968</u>			2b. HOUR <u>11:30</u> AM		
3. SEX <u>Male</u>			4. RACE <u>White</u>			5. DATE OF BIRTH <u>October 28, 1914</u>			6. AGE (In years last birthday) <u>53</u> YRS		
7a. BIRTHPLACE (State or foreign country) <u>Delaware</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <u>Wicomico</u> Md.		
10. CITY OR TOWN OF DEATH <u>Salisbury</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Peninsula General Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Employee of Cozy-Goop</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Del.</u>			13b. COUNTY <u>Sussex</u>			13c. CITY OR TOWN <u>Selbyville</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <u>Selbyville, Del.</u>			14. FATHER'S NAME First <u>Edward</u> Middle <u>Pepper Sr.</u> Last <u>Pepper</u>			15. MOTHER'S MAIDEN NAME First <u>Elizabeth</u> Middle <u>Pepper</u> Last <u>Pepper</u>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u> (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO <u>221-09-2805</u>			17. INFORMANT <u>Gordon Pepper</u>			Address <u>Berlin, Md.</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma</u> <u>571.8</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Esophageal varices, bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Portal cirrhosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>5816</u>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State			22a. I certify that (I) (this hospital) attended the deceased from <u>4-19</u> , 19 <u>68</u> , to <u>4-20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>E. Kent Carney</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type) <u>E. Kent Carney, M.D.</u>			22e. ADDRESS <u>Medical Center, Salisbury, Md.</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		
23b. DATE <u>April 24, 1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Roxana Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Roxana, Sussex, Del.</u>			24. FUNERAL DIRECTOR <u>A. Douglas Nelson, Frankford, Del.</u>		
25a. REC'D BY REGISTRAR DATE <u>APR 26 1968</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			25c. REGISTRAR'S SIGNATURE			25d. REGISTRAR'S SIGNATURE		

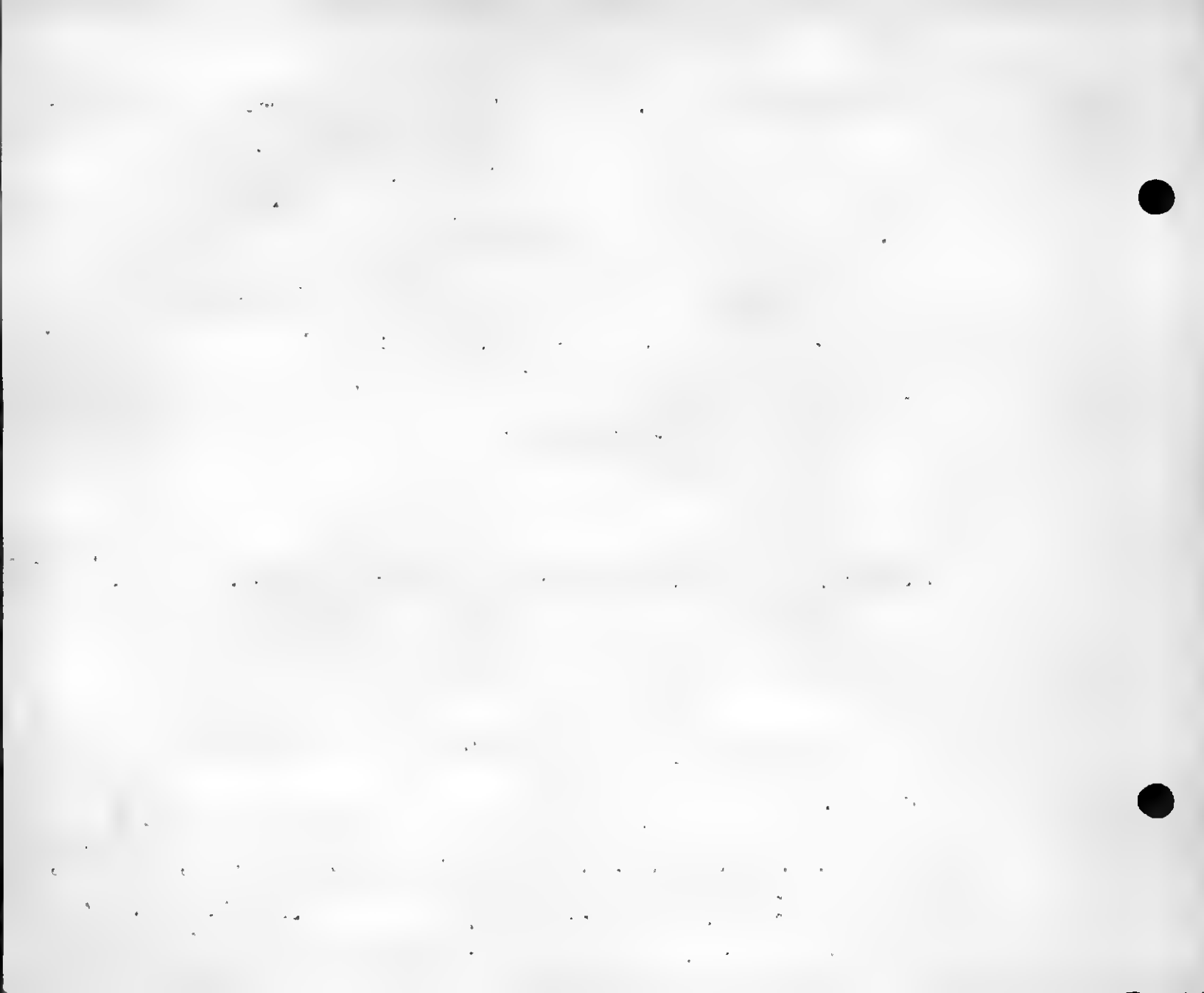


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

00653		6653	
1 DECEASED NAME (Type or print) <b>FREDERICK</b>		First Middle Last <b>O. PORTER</b>	
2a DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1968</b>		2b HOUR <b>12:50AM</b>	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>SEPT 13, 1889</b>	
6 AGE (In years last birthday) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <b>MD</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>WICOMICO</b>		Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hospital</b>	
12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Trappe</b>	
13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>RFD #2, Box 152</b>	
14. FATHER'S NAME First Middle Last <b>CHARLES W. PORTER</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>MARGARET GARRETT</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	
17 INFORMANT <b>RUSSELL PORTER</b>		Address <b>BASTON MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>485X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>491X</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Acute pyelonephritis</b> <b>Osteomyelitis following status postoperative reduction frac. left hip. tis</b>			
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 23, 1968</b> to <b>April 10, 1968</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>April 10, 1968</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.			
22b SIGNATURE <b>C. H. Winnacott</b>		22c DATE SIGNED <b>4/10/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>C. H. Winnacott, M. D.</b>		22e ADDRESS <b>Maryland Deer's Head State Hospital, Salisbury.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <b>APR. 12, 1968</b>	
23c NAME OF CEMETERY OR CREMATORY <b>DENTON</b>		23d LOCATION (City or Town) (County) (State) <b>DENTON CAR. MD.</b>	
24 FUNERAL DIRECTOR <b>CHARLES MOORE</b>		25a REC'D BY REGISTRAR <b>DENTON</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>APR 18 1968</b>	





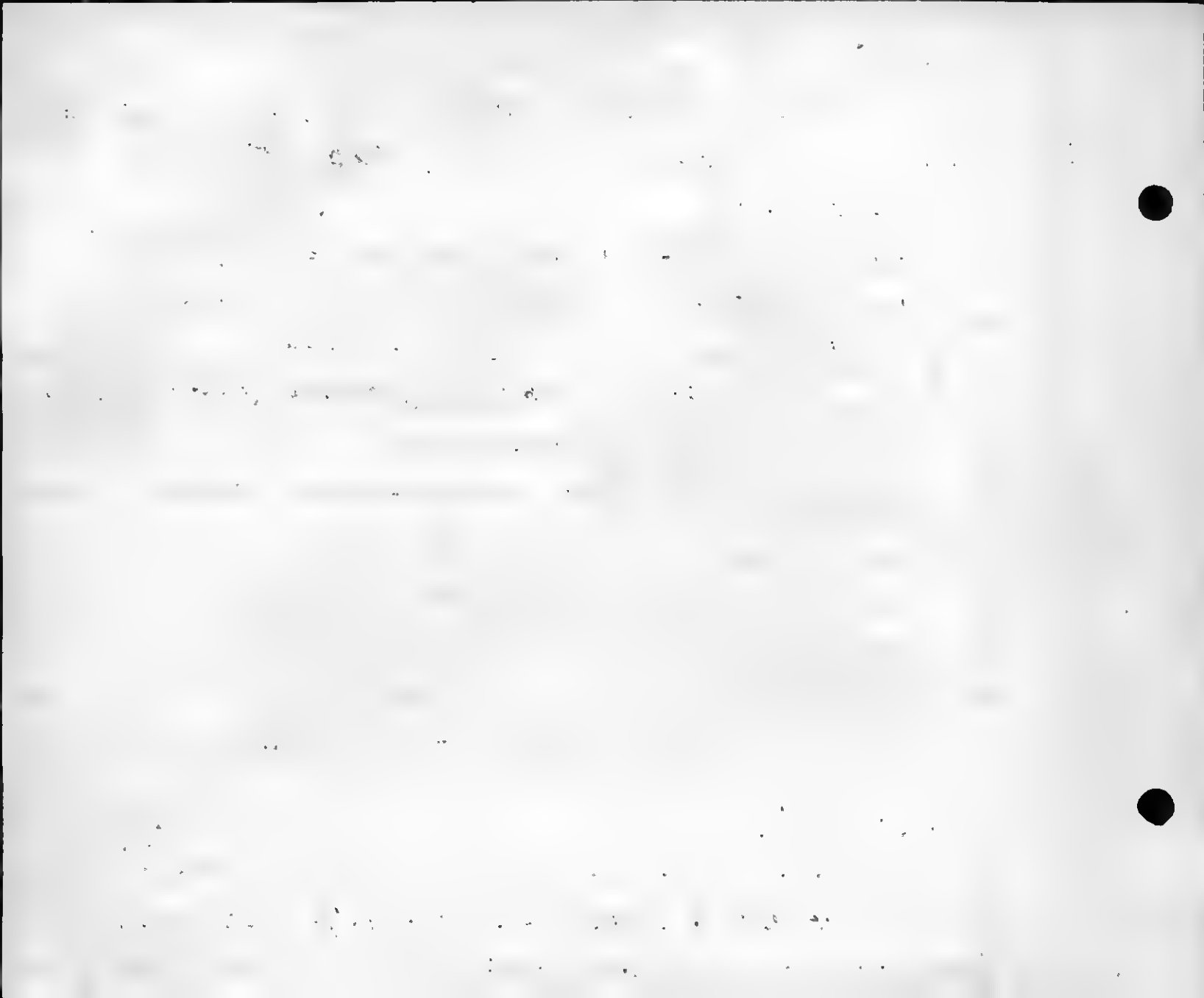
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
MYRTLE CULVER ROBINSON					April 15 1968		1:50P	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	White		6/5/1910		57 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
DELAWARE		USA				WICOMICO Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
Salisbury			Deer's Head State Hospital			HOUSEWORK		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
Maryland			Wicomico		Mardela	YES <input type="checkbox"/> NO <input type="checkbox"/>		Spring Grove Road
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle Last
ARIS F. CULVER					ALICE HEARN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT Address				
No		212-09-7711		HARRY R. ROBINSON, MARDELA, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 3414 DUE TO, OR AS A CONSEQUENCE OF (b) Neurological disease - undetermined etiology Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) 18 months								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 355X								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (A) (this hospital) attended the deceased from September 11 19 67, to April 15 19 68, that (A) (we) last saw the deceased alive on April 15 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (do not) view the body after death.								
22b. SIGNATURE A. C. Mitchell M.D.						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/15/68
22d. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.				22e. ADDRESS Deer's Head State Hospital, Salisbury, Maryland				
23a. BURIAL, CREMATION, EPMO (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL		4/19/1968		MARDELA CEMETERY		MARDELA, MD		
24. FUNERAL DIRECTOR NEWNAM FUNERAL HOME, SHARPTOWN, MD				25a. REC'D BY REGISTRAR DATE APR 18 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



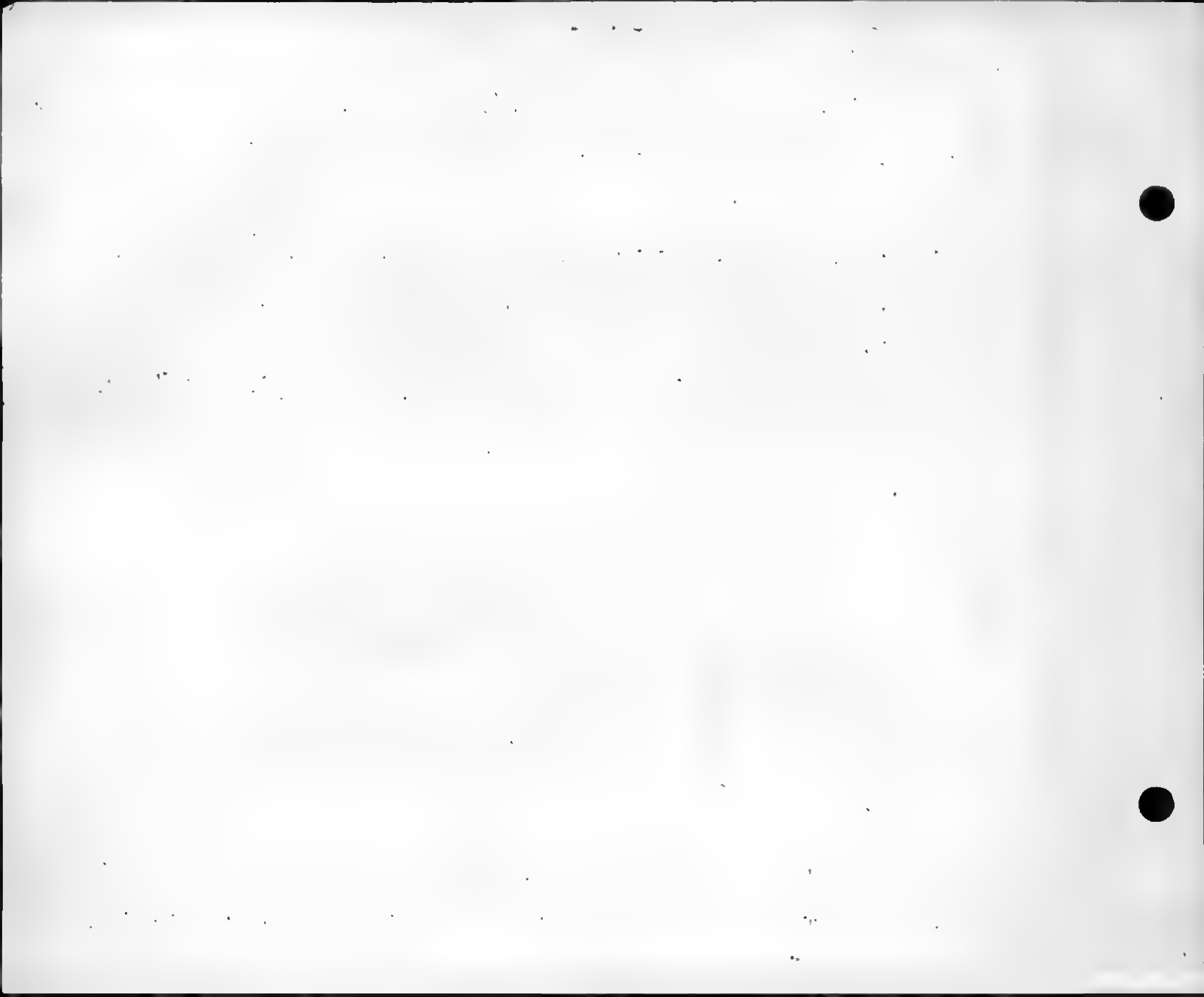
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <span style="float: right;">First Middle Last</span> <b>JOHN HOWARD RYAN</b>			2a. DATE OF DEATH <b>APRIL</b> Month <b>21</b> Day <b>1968</b> Year			2b. HOUR <b>8 P.</b> M.		
3 SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>February 4, 1912</b>		6. AGE (in years last birthday) <b>56</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Owner &amp; Operator</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>424 Washington Street</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Trucking Co.</b>					
14. FATHER'S NAME First Middle Last <b>Jonathan Ryan</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Muriel Roberts</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-10-9895</b>		17. INFORMANT (Wife) <b>Mrs. Marion H. Ryan, Salisbury, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma lung</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>3-1</b> , 19 <b>68</b> , to <b>4-21</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4-21</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>April 22, 1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Dr. E. Kent Carney</b>				22e. ADDRESS <b>Medical Center, Salisbury, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>April 24, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mardela Memorial Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Mardela, Wicomico, Maryland</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REG. BY REGISTRAR <b>APR 25 1968</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION



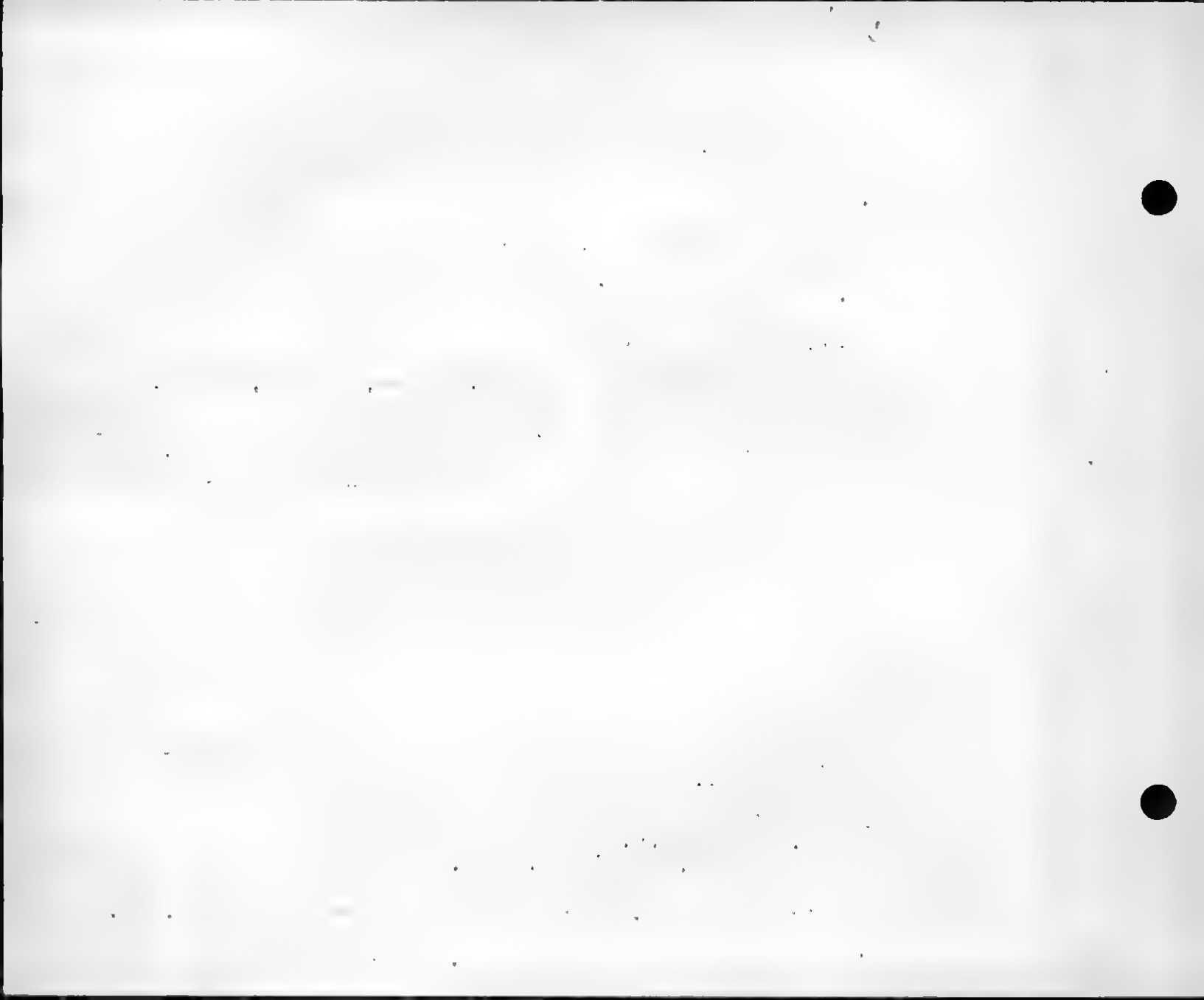
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

00255 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <b>EDITH SHORES</b>			2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>4-19-68</b> 19			2b HOUR <b>12:30</b> P. M.					
3 SEX <b>F</b>	4 RACE <b>W</b>	5 DATE OF BIRTH <b>12-22-02</b>	6 AGE (In years last birthday) <b>65</b> YRS	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month <b>4</b> Day <b>19</b> Year <b>1968</b>			2d HOUR <b>12:30</b> P. M.		
7a BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Wicomico</b> Md					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>			12b KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Somerset</b>		13c CITY OR TOWN <b>Wenona</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Box 47</b>		
14 FATHER'S NAME First <b>Harry</b> Middle <b>Lasker</b> Last <b>Lasker</b>				15. MOTHER'S MAIDEN NAME First <b>Sarah</b> Middle <b>Low</b> Last <b>Low</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO <b>unknown</b>		17. INFORMANT ADDRESS <b>Martin Shore, Wenona, Maryland</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>4107</b> (b) <b>Arteriosclerotic cardio-vascular disease</b> years DUE TO, OR AS A CONSEQUENCE OF (c) <b>years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>none</b>											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>April 20, 1968</b>
EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>			ADDRESS (street, city, town, or county)								
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>			23d LOCATION (City or Town) (County) (State) <b>Wenona Som. Md.</b>				
24 FUNERAL DIRECTOR <b>Leroy Webster</b> ADDRESS <b>Webster Funeral Home, Deal Island, Md.</b>						25a REC'D BY REGISTRAR DATE <b>APR 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

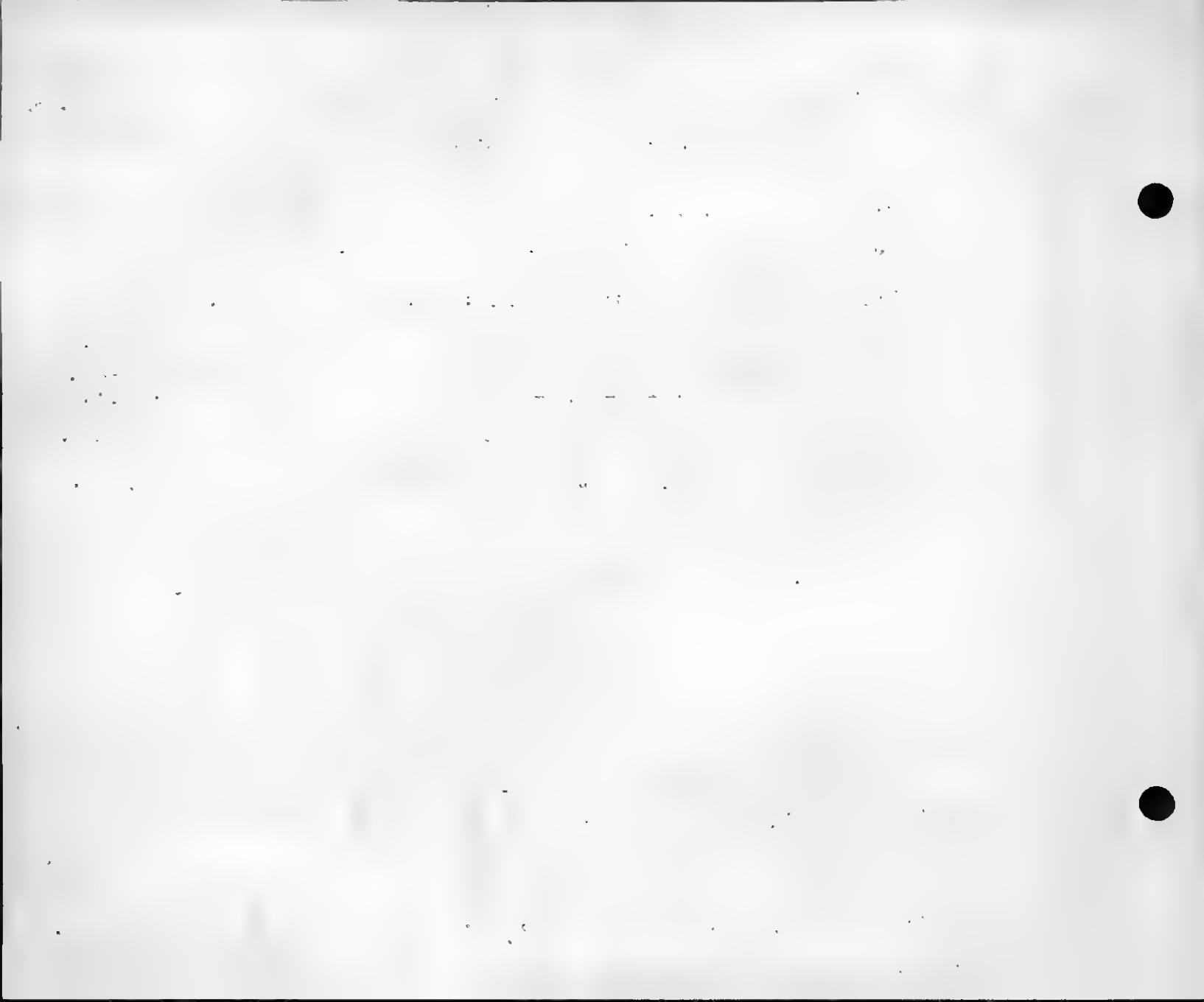


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) <b>WELFORD</b>		First Middle Last <b>SIMS</b>		2a. DATE OF DEATH <b>APRIL</b> Month <b>26</b> Day <b>68</b> Year		2b. HOUR <b>3:35pm</b>	
3 SEX <b>Male</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>4/7/90</b>		6. AGE (In years last birthday) <b>78</b> YRS.	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WICOMICO</b> Md.	
10 CITY OR TOWN OF DEATH <b>SALISBURY</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DEERSHEAD</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institut an- Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c CITY OR TOWN <b>Cambridge</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last <b>James Sims</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Sarah Jackson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>218-07-5421</b>	
17. INFORMANT <b>Elnora Dickerson</b>		Address <b>Phila-Pa. 339 Winter t.</b>		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE CORONARY THROMBOSIS</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF GENERALIZED ARTERIOSCLEROSIS (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Hrs.</b> <b>4 Yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201 B. LATERAL AMPUTEE</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles H. Jones</b> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>4/30/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Netipquin, Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Netipquin Wicomico Md.</b>	
24. FUNERAL DIRECTOR <b>Clinton E. Steiner</b> ADDRESS <b>Salisbury</b>				25a. REC'D BY REGISTRAR <b>DATE MAY 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>	





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>LILLIE MAE SMITHERS</b>		First Middle Last		2a. DATE OF DEATH Month Day Year <b>APRIL 14 1968</b>		2b. HOUR <b>7:34 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>Oct 10, 1890</b>		6. AGE (n years lost birthday) <b>77</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital name of place of death) <b>Benedicta General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done or last of working life, even if retired) <b>Housework</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Dorchester</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>6 Maryland Ave</b>		14. FATHER'S NAME First Middle Last <b>Theopolis Harley</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Sarah Nellie</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>215-48-2748</b>		17. INFORMANT <b>Clarence Smith</b>		Address <b>Dorchester, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thromboses</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis Heart Disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerosis Heart Disease</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/4</b> , 19 <b>68</b> , to <b>4/14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>4/14/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Harold J. Gilmore</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>4/17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Stephens</b>		23d. LOCATION (City or Town) (County) (State) <b>Dorchester Dorchester Del.</b>	
24. FUNERAL DIRECTOR <b>William M. Marvel</b>				ADDRESS <b>Dorchester Del.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 18 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

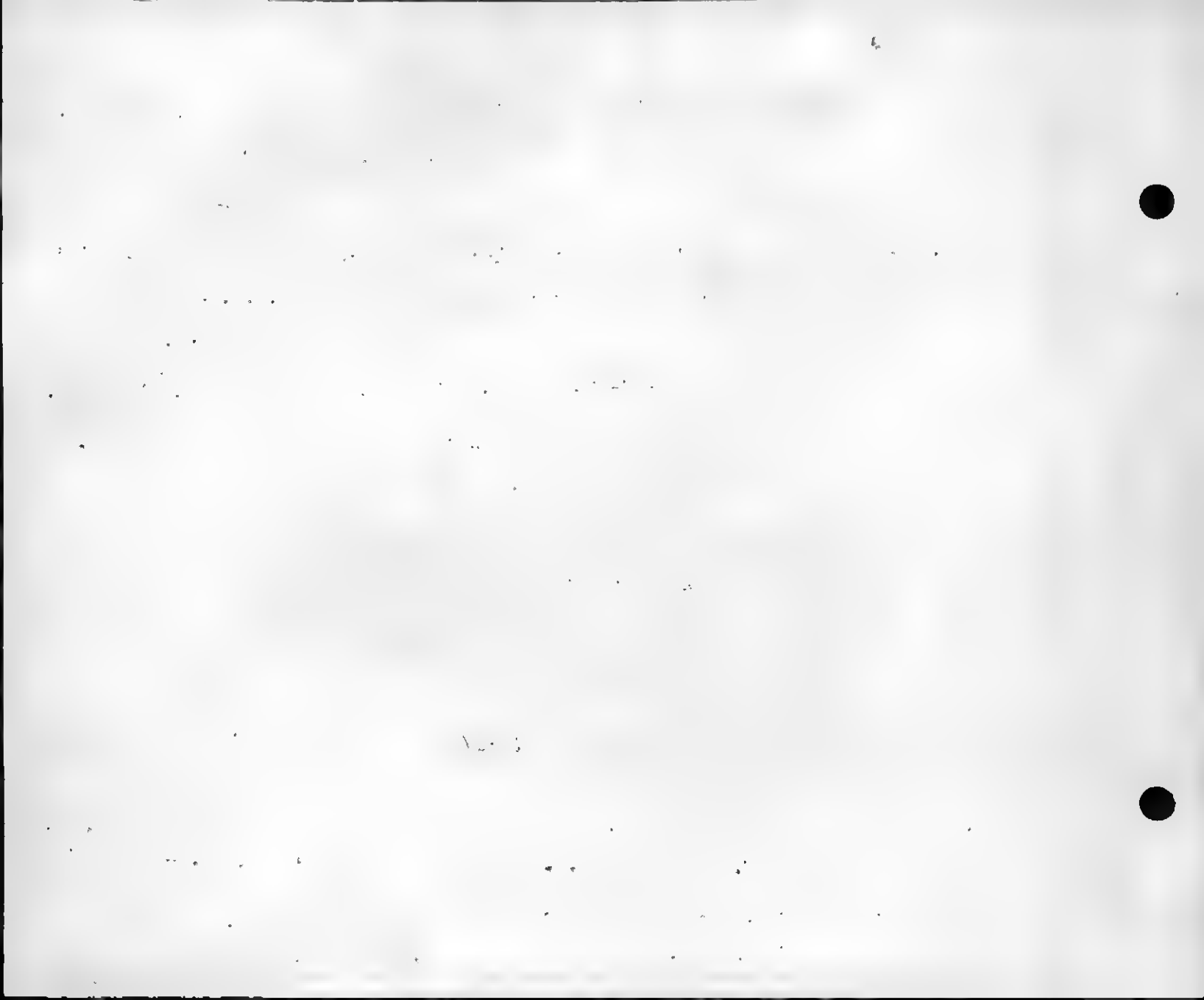


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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Willie			Lewis			Wagstaff			Month Day Year 2:55 PM		
3 SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)		
Male			Colored			November 2, 1891			76 YRS		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
North Carolina			USA						Wicomico Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Deer's Head State Hospital			Retired Coal Miner			Coal Mining		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Maryland			Wicomico			Mardela Springs			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
First Middle Last			First Middle Last			R.F.D. #1					
Abe Wagstaff			Lucy Anne (maiden name unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
No			232-12-4925			Mrs. Mable Wagstaff, Mardela Springs, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Embolus</u>										1 Hr.	
4404 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
45 Anthracosis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/31/68</u> , 19 <u>68</u> , to <u>4/27/68</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>4/27/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Charles H. Winnacott</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED April 27, 1968		
22d. PHYSICIAN'S NAME (Type) <u>Charles H. Winnacott, M.D.</u>						22e. ADDRESS <u>Box 2018, Salisbury, Md. - 21801</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			May 3, 1968			Green Acres Cemetery			Salisbury, Maryland		
24. FUNERAL DIRECTOR <u>From Trumpton, Federalburg, Maryland</u>						25a. MAY REGISTRAR DATE <u>3 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



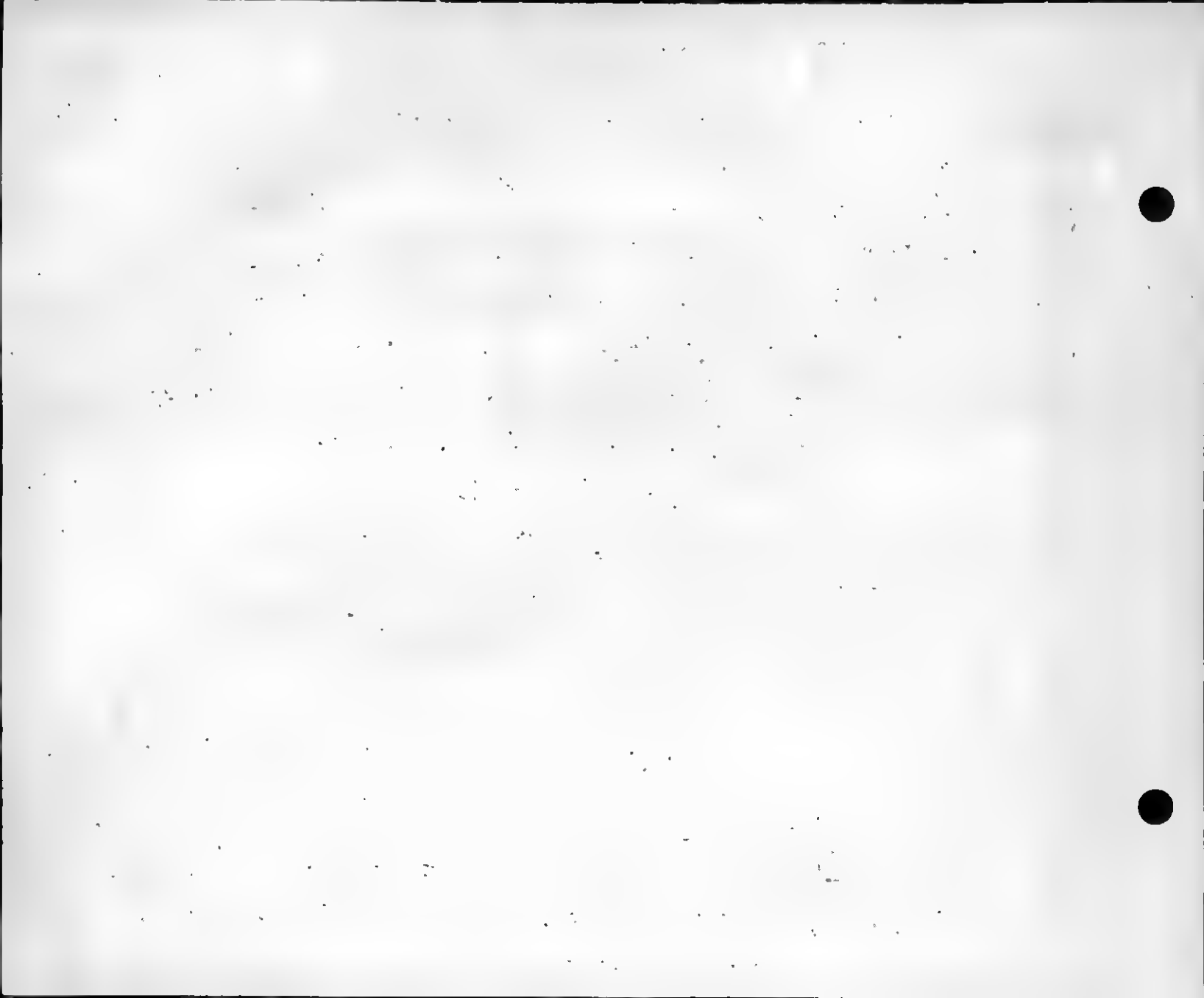
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Robert Wackford</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>April 2 1968</b>			2b. HOUR <b>6:30</b> M.		
3 SEX <b>male</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>3/24/1894</b>			6 AGE (In years last birthday) <b>74</b> YRS		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			B MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Wicomico</b> Md		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>			12a. USUA. OCCUPATION (Kind of work done during last of working life, even if retired) <b>Mechanic</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>Wicomico</b>			13c. CITY OR TOWN <b>Nantuxoke</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME <b>Robert F. Walter</b>			First Middle Last			15 MOTHER'S MAIDEN NAME <b>Annie Lee Willing</b>			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-16-3960</b>			17 INFORMANT <b>Alice Walter, Nantuxoke, Md.</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intractable Heart Failure</b> <b>410.9</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>45</b> (b) <b>Myocardial Infarction</b> (c) <b>Coronary Arteriosclerosis (Diffuse)</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b> <b>16 days</b> <b>Not Known</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Anemia.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/17/68</b> to <b>4/2/68</b> , that (I) (we) last saw the deceased alive on <b>4/1/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>[Signature]</b>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>4/2/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>David Gilmore</b>			22e. ADDRESS <b>58156th, Maryland</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>4/2/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Tyaskin, Wicomico, Md</b>		
24. FUNERAL DIRECTOR <b>C. J. Rossini, BIVILLE, MD</b>			ADDRESS			25a. REC'D BY REGISTRAR DATE <b>APR 3 1968</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION



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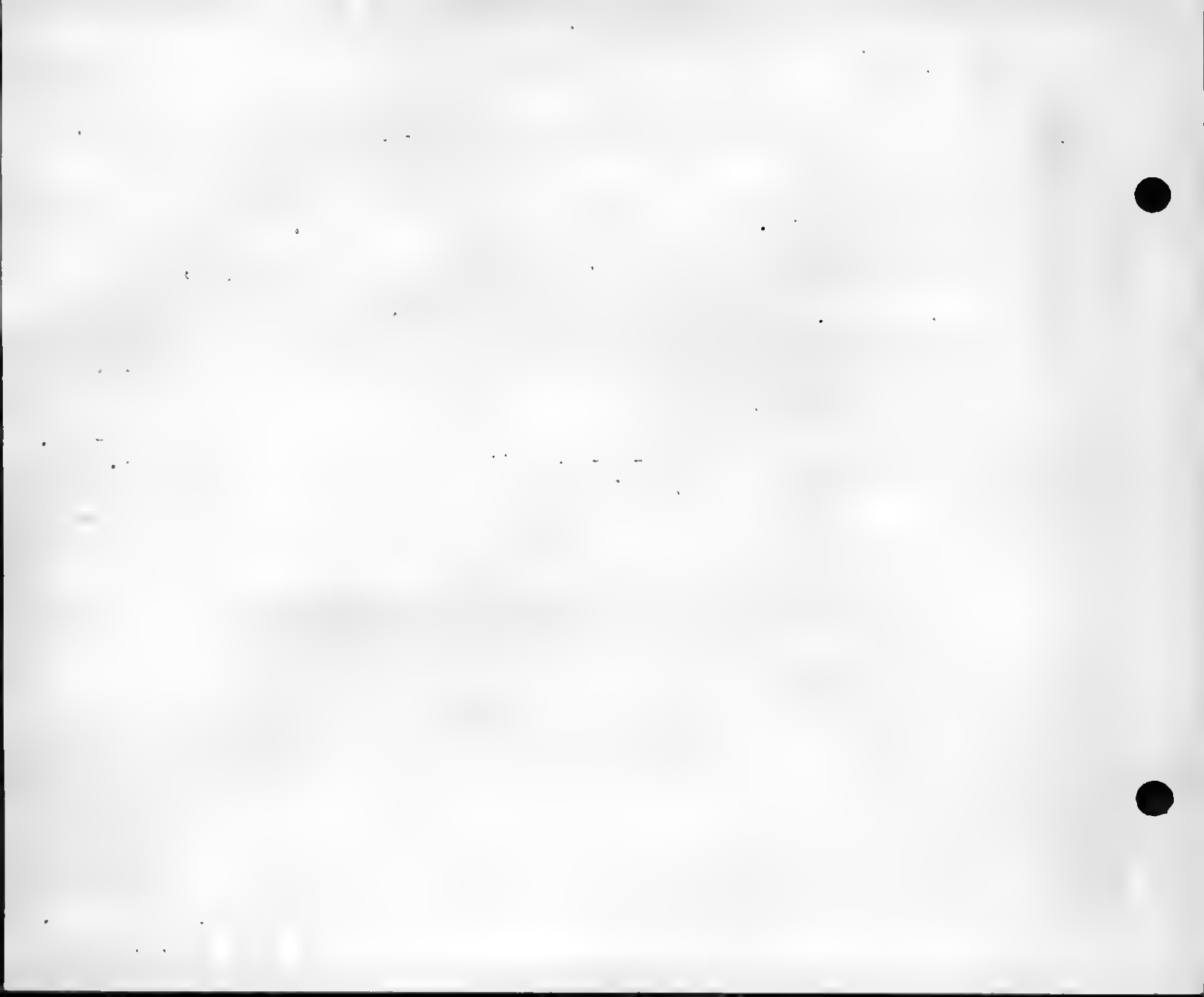
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00262

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>128 Second St.</u>		d. STREET ADDRESS <u>128 Second St.</u>	
3. NAME OF DECEASED (Type or print) <u>Emme M. Wallace</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1968</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1885</u>
9. AGE (in years lost birthday) yrs. <u>82</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Church</u>		14. MOTHER'S MAIDEN NAME <u>Mary Church</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-50-1484</u>	
17. INFORMANT <u>Anthony Burris</u>		Address <u>Salis- Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>1 Apr 1968</u> to <u>8 May 1968</u> , that (I) (we) last saw the deceased alive on <u>8 May 1968</u> and that death occurred at <u>12:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>E. A. Purnell</u>		22b. DATE SIGNED <u>9 Apr 68</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. A. Purnell, MD</u>		22d. ADDRESS <u>652 W MAIN ST, Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/12/1968</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>	23d. LOCATION (City or Town) (County) (State) <u>Salisbury Wicomico Md.</u>
24. FUNERAL DIRECTOR <u>Winton S. Stewart Salis Md.</u>		25. REC'D BY REGISTRAR DATE <u>APR 16 1968</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



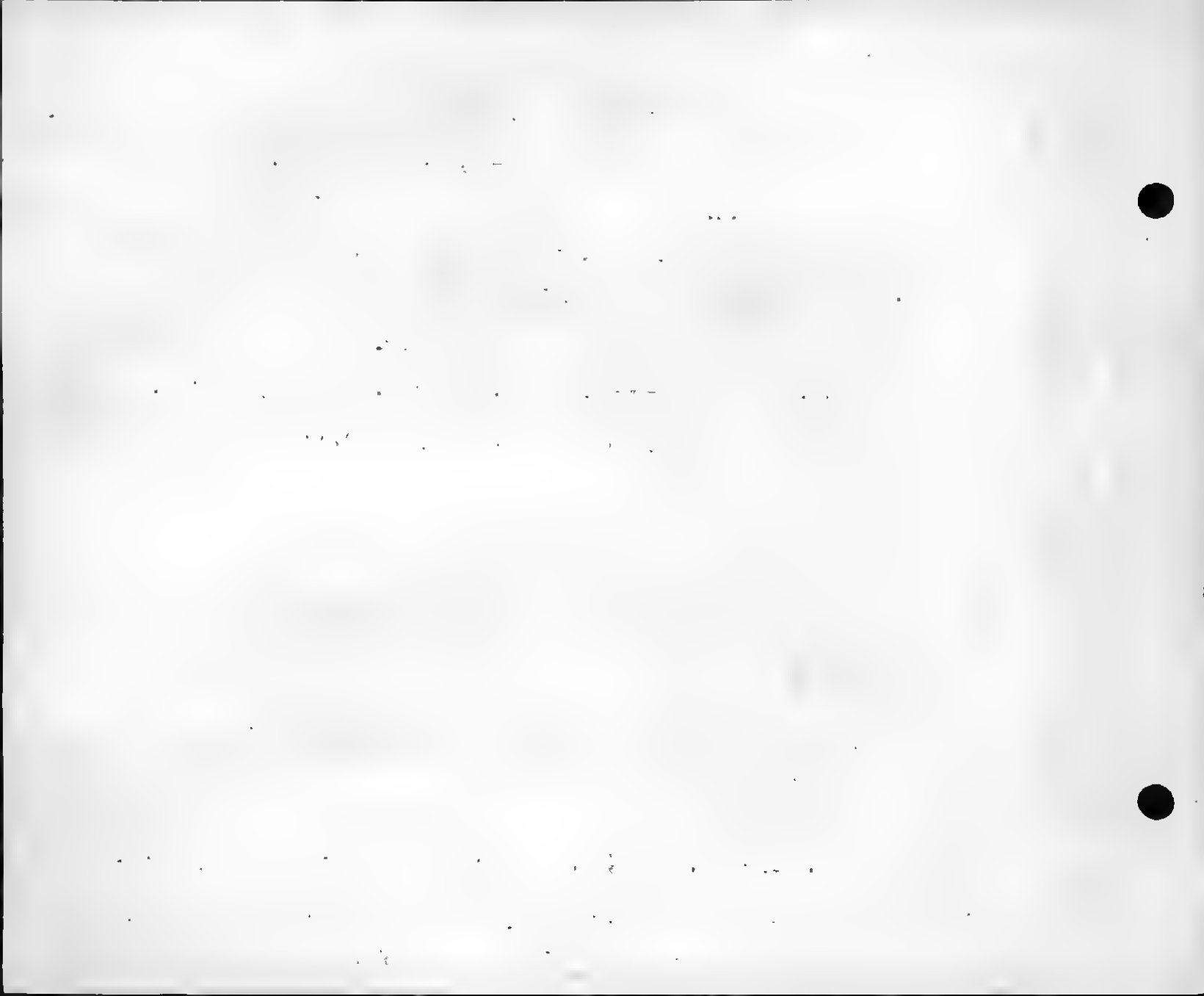


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last SAMUEL GARDNER WHEATLEY					2a. DATE OF DEATH Month Day Year 4 22 1968			2b. HOUR 7A. M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2-10-1890			6. AGE (In years lost birthday) 78 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.				
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Owner	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt #1	
14. FATHER'S NAME First Middle Last Charles Henry Wheatley					15. MOTHER'S MAIDEN NAME First Middle Last Arianna White					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes			16b. SOCIAL SECURITY NO. W.W.I. 217-36-0124		17. INFORMANT Address Mrs. Minnie H. Wheatley, See Sec. 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>chronic nephritis</u> 582X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH intermittent										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>582X</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>4-4</u> , 19 <u>68</u> , to <u>4-23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>4-15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Wilber R. Ellis, Jr.</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-23-68			
22d. PHYSICIAN'S NAME (Type) Dr. Wilber R. Ellis, Jr.					22e. ADDRESS Medical Center Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-26-1968		23c. NAME OF CEMETERY OR CREMATORY Siboom Cemetery		23d. LOCATION (City or Town) (County) (State) Siboom Wicomico, Md.				
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland					25a. REC'D BY REGISTRAR DATE APR 29 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



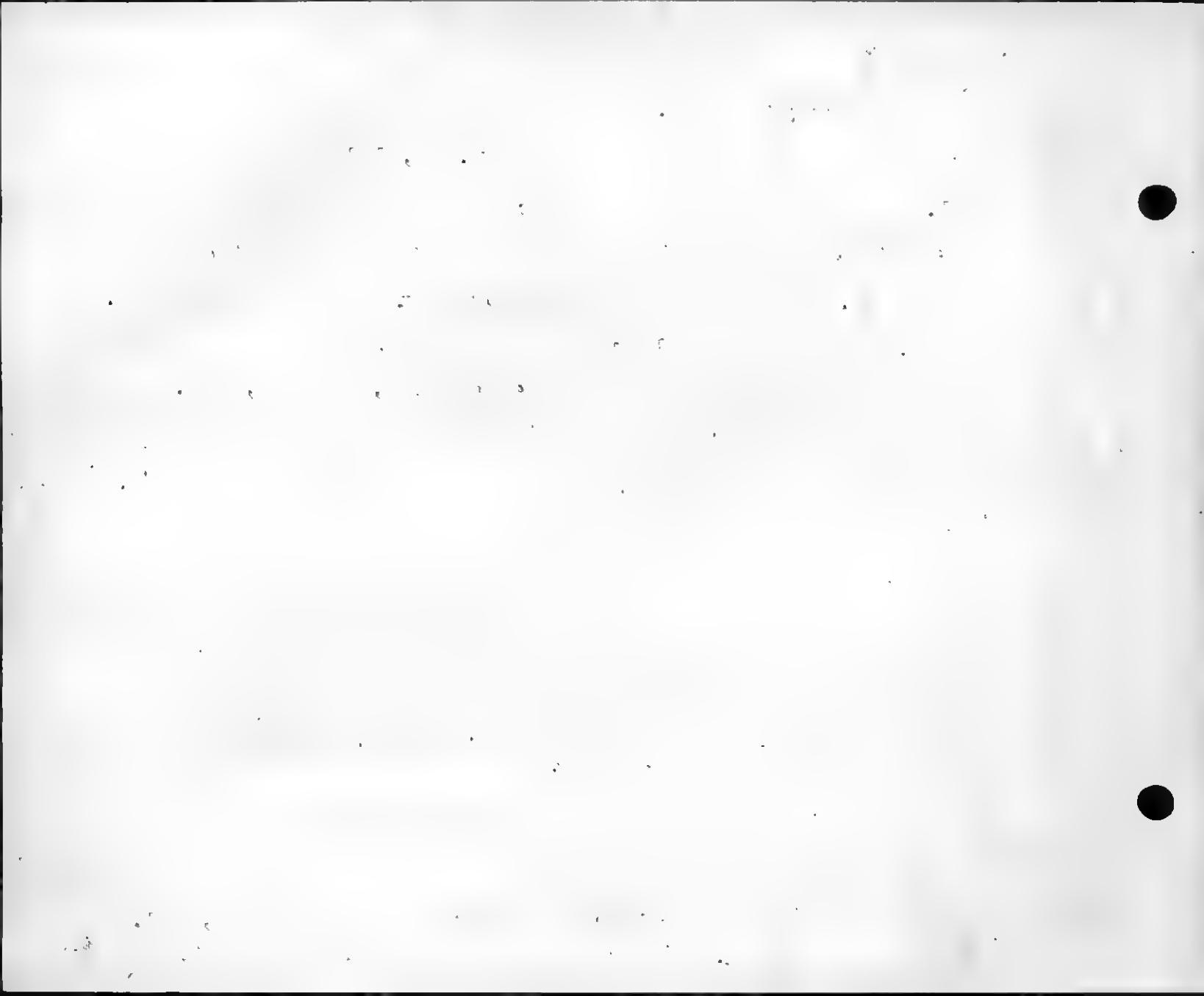
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <b>Dorothy M. Woodbury</b>		First <b>by</b> Middle <b>M.</b> Last <b>Woodbury</b>		2a. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>68</b>			2b. HOUR <b>12:15</b> M		
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>Apr. 25, 1917</b>			6. AGE (In years last birthday) <b>50</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Del.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md			
1d. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Chippewa Blvd.</b>	
14. FATHER'S NAME First <b>Ebb</b> Middle <b>Waller</b> Last <b>Short</b>		15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>Short</b> Last <b>Short</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>no</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Anna Short, Milton, Del.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Yellow Atrophy of Liver.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>(Probable) Infectious Hepatitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Not Known</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>0928</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Pneumonia.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes.</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/5/1968</b> to <b>4/10/1968</b> , that (I) (we) last saw the deceased alive on <b>4/10/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>[Signature]</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4/13/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Antioch Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Frankford, Del.</b>			
24. FUNERAL DIRECTOR <b>William Bergey, Milford, Del.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>APR 19 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Item 2a Film G399  
4/17/68  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06370

1. DECEASED NAME (Type or Print) <b>Ruben James Wright</b>			2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> Month <b>4</b> Day <b>1</b> Year <b>1968</b>			2b. HOUR <b>M</b>			
3. SEX <b>M</b>	4. RACE <b>AA</b>	5. DATE OF BIRTH <b>5-9-1920</b>	6. AGE (In years last birthday) <b>48</b> YRS.	IF UNDER 1 YEAR MONTHS <b>2</b> DAYS <b>2</b>	IF UNDER 24 HRS. HOURS <b>1</b> MIN.	2c. DATE PRONOUNCED DEAD Month <b>4</b> Day <b>1</b> Year <b>1968</b>			2d. HOUR <b>M</b>
7a. BIRTHPLACE (State or foreign country) <b>Wicomico</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b>			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>705 Rose St.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Lab</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>705 Rose St.</b>		
14. FATHER'S NAME First <b>Shellie</b> Middle <b>Wright</b> Last <b>Wright</b>			15. MOTHER'S MAIDEN NAME First <b>Lattie</b> Middle <b>Wright</b> Last <b>Wright</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>1</b>		17. INFORMANT ADDRESS <b>Lattie Wright</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Status Epilepticus</b> <b>3452</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>3532</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <b>April 4, 1968</b>			
ADDRESS (Street, city, town, or county) <b>409 Camden Ave. Salisbury, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-5-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury Wicomico Md</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Booker West Funeral Home, Salisbury, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 9 - 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

all papers must be filed in the proper place  
in the file and must be kept in the file

THE  
OFFICE

1. The first thing I did was to go to the  
office and see what was going on.  
2. I found that the office was in a  
state of confusion and that the  
files were in a state of confusion.  
3. I then went to the files and found  
that the files were in a state of  
confusion and that the files were in a  
state of confusion.  
4. I then went to the files and found  
that the files were in a state of  
confusion and that the files were in a  
state of confusion.  
5. I then went to the files and found  
that the files were in a state of  
confusion and that the files were in a  
state of confusion.  
6. I then went to the files and found  
that the files were in a state of  
confusion and that the files were in a  
state of confusion.  
7. I then went to the files and found  
that the files were in a state of  
confusion and that the files were in a  
state of confusion.  
8. I then went to the files and found  
that the files were in a state of  
confusion and that the files were in a  
state of confusion.  
9. I then went to the files and found  
that the files were in a state of  
confusion and that the files were in a  
state of confusion.  
10. I then went to the files and found  
that the files were in a state of  
confusion and that the files were in a  
state of confusion.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
Item 13 Taken from birth cert. <b>CERTIFICATE OF DEATH</b>												
1. DECEASED-NAME (Type or print) <i>Baby Jean</i>			First Middle Last <i>WYATT</i>			2a. DATE OF DEATH Month <i>APRIL</i> Day <i>12</i> Year <i>1968</i>			2b. HOUR <i>12</i> P.M.			
3. SEX <i>Male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>4-12-68</i>			6. AGE (In years last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Salisbury</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i>						
10. CITY OR TOWN OF DEATH <i>Salisbury</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Pittsville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Box 25</i>			
14. FATHER'S NAME First Middle Last <i>Walter Dale</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Peggy Wyatt</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Cornelius Wyatt - Pittsville Md. Box 25</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Immaturity (850 Gms)</i> <i>777X</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>776X</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <i>4/11, 1968</i> , to <i>4/12, 1968</i> , that (I) (we) lost saw the deceased alive on <i>4/12, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>D.S. Anderson</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4-17-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Acres Mem. Park</i>		23d. LOCATION (City or Town) <i>Salisbury</i>		(County) <i>Wic.</i>		(State) <i>Md.</i>		
24. FUNERAL DIRECTOR <i>Loretta &amp; Jolley Johnson</i>						ADDRESS <i>1012 Salisbury</i>		25a. REC'D BY REGISTRAR DATE <i>APR 22 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945

1944-1945